Draft ICD-10-CM Official Guidelines
For Coding and Reporting for Acute Short-term and Long-term Hospital Inpatient and Physician Office and other Outpatient Encounters

Introduction

The National Center for Health Statistics (NCHS), one of the Centers for Disease Control and Prevention (CDC), an agency within the United States Department of Health and Human Services (DHHS), presents the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official government version of the ICD-10-CM.

The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO). The ICD-10 is used in the United States solely as a mortality classification for the coding of death certificates. A morbidity classification contains substantially more detail than is required in a mortality classification. It does include conditions that are potentially fatal, but which are, at least to some degree, treatable. No strictly fatal conditions, such as decapitation, are included, the exceptions being codes for stillbirth, and death NOS, for a patient who has died and is brought to an emergency department (ED) to be pronounced dead.

The United States is bound by international treaty to report mortality data to the WHO using ICD-10 codes. Where a note in the ICD-10-CM Tabular List indicates that a category or categories have been deactivated, it is a category from the ICD-10 that is not for use with the ICD-10-CM. The notes are for those who wish to compare data between ICD-10 and ICD-10-CM.

The ICD-10-CM is in the public domain, however, neither categories nor code titles may be altered in any way, except through the Coordination and Maintenance process, the annual updating procedure overseen jointly by NCHS and the Centers for Medicare and Medicaid Services (CMS).

There are no codes for procedures in the ICD-10-CM. Procedures are coded using the procedure classification appropriate for the encounter setting.

These guidelines for coding and reporting appear on the official government version of the ICD-10-CM and on the NCHS website. (add website address)

These conventions and guidelines apply to the proper use of ICD-10-CM for acute short-term and long-term hospital inpatient and physician office and other outpatient settings. The guidelines will be reviewed on an annual basis corresponding to the annual update to the ICD-10-CM. New guidelines will be written to correspond to new codes that are added to ICD-10-CM or for types

of encounters for which no guidelines exist. The term “encounter" in these guidelines is used generally to mean a health care encounter, including an inpatient admission.

The guidelines are organized into several sections: Section 1, ICD-10-CM conventions, Section 2, General coding guidelines, and Section 3, Chapter-specific guidelines. The chapter-specific guidelines are sequenced in the same order they appear in the Tabular List. **It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.**

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Section I: ICD-10-CM Conventions

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Index and Tabular List of the ICD-10-CM as instructional notes. The conventions are applicable to all health care settings.

The conventions are as follows:

I.a Format

The ICD-10-CM is divided into the Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a chronological list of codes divided into chapters based on body system or condition. The Index is divided into two parts, the Index to Diseases and Injury, and the Index to External Causes of Injury. Within the Index of Diseases and Injury there is a Neoplasm Table and a Table of Drugs and Chemicals. See guideline 2.1 for instructions on use of the Neoplasm Table and guideline 19.3.2 for instructions on the use of the Table of Drugs and Chemicals.

The ICD-10-CM uses an indented format for ease in reference. The Tabular List contains categories, subcategories and codes. Each character for all categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. The first character of a category is a letter. The second and third characters are numbers. A 3 character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Subcategory characters may be either letters or numbers. Codes are either 4, 5 or 6 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. The final character in a code may be either a letter or a number.

The ICD-10-CM utilizes dummy place holders, always the letter x. A dummy "x" is used as a 5th character place holder at certain 6 character codes to allow for future expansion. The best example of this is at the poisoning codes, categories T36-T50, and the toxic effect codes, categories T51-T65.

The 6th character for the codes at categories T36-T50 always indicates the intent:
unintentional (accidental)
intentional self-harm
assault
undetermined
or an adverse effect
or underdosing
The 6th character for the codes at categories T51-T65 always indicates the intent.

The 5th character x will permit the future expansion of these codes without disturbing the 6th character structure.

Certain categories have applicable 7th character extensions. The extension is required for all codes within the category, or as the notes in the tabular instruct. The extension must always be the 7th character in the data field. If a code is not a full 6 characters, a dummy place holder x must be used to fill in the empty characters when a 7th character extension is required.

All codes on the official version of the ICD-10-CM are in bold. **Only codes are permissible for reporting purposes, not categories or subcategories. For codes with applicable extensions the extension is required at the 7th character for reporting purposes.**

I.b Punctuation

[ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Index to identify manifestation codes. (see-Code first/Use additional code convention)

( ) Parentheses are used in both the Index and Tabular List to enclose supplementary words which may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

: Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

I.c Use of "and"
When the term "and" is used in a narrative statement it represents and/or.

I.d "Other specified" codes (NEC)
Codes titled "Other..." or "Other specified..." in the Tabular List (usually a code with a 4th or 6th character 8 or z and fifth character 9) are for use when the information in the medical record provides detail for which a specific code does not exist.

The abbreviation NEC, "Not elsewhere classifiable" represents "other specified" in the ICD-10-CM. An index entry that states NEC directs the coder to an "other specified" code in the Tabular List (see- Inclusion terms).

I.e "Unspecified" codes (NOS)
Codes in the Tabular List with "Unspecified..." in the title (usually a code with a 4th or 6th character 9 and 5th character 0) are for use when the information in the medical record is insufficient to assign a more specific code. The abbreviation NOS, "Not otherwise specified", in the Tabular List is the equivalent of unspecified.

I.f Includes notes
The word "Includes" appears immediately under certain categories to further define, or give examples of, the content of the category.

I.g Inclusion terms
Lists of terms are included under some codes. These terms are some of the conditions for which that code number is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of some of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Index may also be assigned to a code.

I.h Excludes notes
The ICD-10-CM has two types of excludes notes. Each note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.

Excludes1
A type 1 Excludes note is a pure excludes. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is for used for when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

Excludes2
A type 2 excludes note represents "Not included here". An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, from but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together.

I.i Code first/use additional code notes (etiology/manifestation paired codes)
Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. See category F02 for an example of this convention.

In addition to the notes in the Tabular list, these conditions also have a specific index entry structure. In the Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

In some circumstances, more than two codes may be required to fully describe a condition. In these cases a "use additional code" note will be present at a complication or manifestation code to indicate that more codes are needed. The additional codes used are secondary codes that are to be sequenced following any underlying cause and following the main manifestation. See code R65.2 for an example of this convention.

I.j Code also note

A "code also" note instructs that two codes may be required to fully describe a condition, but the sequencing of the two codes depends on the severity of the conditions and the reason for the encounter. See subcategory H05.32 for an example of this convention.

I.k With/without note

When "with" and "without" are the two options for the final character of a set of codes, the default is always "without." For five-character codes, a "0" as the fifth-position character represents "without", and "1" represents "with." For six-character codes, the sixth-position character "1" represents "with" and "9" represents "without."

Section II: General Coding Guidelines

The listing of diagnoses in the medical record is the responsibility of the attending physician. A joint effort between the attending physician and the coder is essential to achieve complete and accurate documentation and code assignment. These guidelines have been developed to assist both the physician and the coder in identifying those diagnoses that are to be assigned.

II.a Locating a code in the ICD-10-CM

To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Index, then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Index and the Tabular List.

It is essential to use both the Index and Tabular List when locating and assigning a code. The index does not always provide the full code. Selection of the full code, including laterality and any applicable extensions can only be done in the Tabular list. A - dash at the end of an index entry indicates that additional characters are required. Even if a dash is not included at the index entry, it is necessary to refer to the Tabular list to verify that no extension is required.

II.b Use of symptom codes with confirmed diagnoses

A symptom code should not be used with a confirmed diagnosis if the symptom is integral to the diagnosis, such as the use of a chest pain code with an acute myocardial infarction (MI) code. Pain is integral to an acute MI.

A symptom code should be used with a confirmed diagnosis if the symptom is not always associated with that diagnosis, such as the use various signs and symptom associated with complex syndromes.

II.c Acute and chronic conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Index at the same indentation level, code both and sequence the acute (subacute) code first.

II.d Combination codes

A combination code is a single code used to classify:
two diagnoses, or
A diagnosis with an associated sign or symptom, or
A diagnosis with an associated complication

Combination codes are identified by referring to subterm entries in the Index and by reading the Includes and Exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Index so directs. Multiple codes should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks the necessary specificity to fully describe all elements of a diagnosis, an additional code(s) may be used.

II.e Laterality

For bilateral sites, the final character of the codes in the ICD-10-CM indicate laterality. The right side is always character 1, the left side character 2. In those cases where a bilateral code is provided the bilateral character is always 3. An unspecified side code is also provided should the side not be identified in the medical record. The unspecified side is either a character 0 or 9 depending on whether it is a 5th or 6th character.

II.f Selection of principal or first listed diagnosis

The code sequenced first on a medical record at the end of an encounter is most important because it defines the main reason for the encounter as determined at the end of the encounter. In the inpatient setting, the first code listed on a medical record is referred to as the principal diagnosis. In all other health care settings it is referred to as the first listed code.

The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40. The UHDDS definition also applies in selection of the first listed diagnosis code in other health care settings.

Selection of principal diagnosis/first listed code is based first on the conventions in the classification that provide sequencing instructions. If no sequencing instructions apply then sequencing is based on the condition(s) that brought the patient into the hospital or physician office and which condition was the primary focus of treatment. Conditions present on admission that receive treatment, but that do not meet the definition of principal diagnosis, should be coded as additional codes.

Additional guidelines on the selection of the principal/first listed code are as follows:

II.f.1 Use of symptom codes as principal/first listed diagnosis

A sign or symptom code (generally codes from Chapter 18 but signs and symptoms codes can be found in the body system chapters as well) is not to be used as a principal diagnosis when a definitive diagnosis for the sign or symptom has been established.

A sign or symptom code is to be used as principal/first listed if no definitive diagnosis is established at the time of coding. If the diagnosis is confirmed (e.g., an X-ray confirms a fracture, a pathology or laboratory report confirms a diagnosis) prior to coding the encounter, the confirmed diagnosis code should be used.

II.f.2 Acute manifestation versus underlying condition

With the UHDDS definition of principal diagnosis in mind, it is generally an underlying condition that precipitates the need for an admission since treatment of the underlying condition generally resolves any associated acute manifestations and is the primary focus of treatment. If the acute manifestation is immediately life-threatening and primary treatment is directed at the acute manifestation the acute manifestation should be sequenced before the underlying condition. If the acute manifestation is not the primary focus of treatment the underlying condition should be sequenced first.

This guideline is also based on the fact that the classification has the etiology/manifestation convention that requires that the underlying etiology take sequencing precedence over the acute manifestation.

There are many combination codes that include both the etiology and an acute manifestation, in which case the single combination code is assigned as the principal/first listed diagnosis and no sequencing decision is necessary.

Sequencing examples of acute manifestation versus underlying condition can be found in the chapter specific guidelines.

II.f.3 Two or more diagnoses that equally meet the definition of principal diagnosis/first listed

In the instance when two or more confirmed diagnoses equally meet the criteria for principal/first listed diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Index, Tabular List and coding guidelines do not provide sequencing direction, any one of the diagnoses may be sequenced first. This rule also applies to the outpatient setting.

II.f.4 Original treatment plan not carried out

If anticipated treatment is not carried out due to unforeseen circumstances, the principal diagnosis/first listed code remains the condition or diagnosis that was planned to be treated.

II.f.5 Complications of surgery and other medical care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis/first listed code.

II.g Selection of secondary diagnoses

In most cases, more than one code is necessary to fully explain a health care encounter. Though a patient has an encounter for a primary reason (the principal/first listed diagnosis), the additional conditions or reasons for the encounter also need to be coded. These codes are referred to as secondary, additional or "other" diagnoses.

For reporting purposes the definition of "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The UHDDS item #11-b defines "Other Diagnoses" as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in an acute care, short-term, hospital setting. This definition also applies to outpatient encounters.

If the attending physician has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded, unless the condition does not meet the definition of "other diagnosis" listed above.

II.g.1 Previous conditions

Some physicians include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital or physician office policy.

II.g.2 Abnormal test findings

Abnormal test findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the abnormal finding should be added.

If the abnormal test finding corresponds to a confirmed diagnosis it should not be coded in addition to the confirmed diagnosis.

Section III: Chapter-specific Coding Guidelines

In addition to the general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to both inpatient and outpatient settings.

Chapter 1: Certain infectious and parasitic diseases

1.1 Human immunodeficiency virus [HIV] disease
The ICD-10-CM has four codes and one subcategory to classify the HIV virus:
Code B20, Human immunodeficiency virus [HIV] disease
Code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status
Code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV]
Code Z20.6, Exposure to HIV virus
Subcategory O98.7, HIV complicating pregnancy, childbirth, and the puerperium

Only code B20 is in Chapter 1. Codes Z21 and Z20.6 are located in Chapter 21, code R75 is located in Chapter 18. Subcategory O98.7 is located in Chapter 15.

Code B20, Human immunodeficiency virus [HIV] disease, is for use for symptomatic HIV patients. That is, patients who have or have had any of the opportunistic infections associated with the HIV virus. This code is synonymous with the terms Acquired immune deficiency syndrome (AIDS), and AIDS-related complex (ARC). Code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is equivalent to the statement "HIV positive." Code Z21 is only for patients who are HIV positive but have never had any opportunistic infections. Once a patient has had a first opportunistic infection that patient is assigned code B20 from then on. They should never again be assigned a Z21 code, even if at a particular encounter no infection or HIV related condition is present. Codes B20 and Z21 should never appear on the same record.

Confirmation of HIV status does not require documentation of positive serology or culture for HIV. The physician's diagnostic statement that a patient is HIV positive, or has an HIV-related illness is sufficient.

Code R75 is for limited use for patients who have an inconclusive lab finding for HIV. It includes newborns of HIV positive mothers whose HIV status has not been confirmed. Code Z20.6, Exposure to HIV virus, is only for use in those instances when a patient believes he/she may have been exposed or come in contact with the HIV virus. See guideline 21.2.5 Contact/ Exposure.

1.1.1 Sequencing of HIV codes

If a patient has a health care encounter for an HIV-related condition, code B20 should be sequenced first (principal/first listed code), followed by additional diagnosis codes for all reported HIV-related conditions. Codes for unrelated conditions should also be coded.

If an HIV patient has a health care encounter for an unrelated condition, such as trauma, the code for the unrelated condition should be sequenced first (principal/first listed code). B20 or Z21 should be added as an additional diagnosis. Any HIV-related diagnosis codes should also added, when applicable, to accompany the B20 code.

1.1.2 HIV in a pregnant patient

Codes from Chapter 15, Pregnancy, childbirth, and the puerperium, are always sequenced first on a medical record. Code O98.7-, HIV complicating pregnancy, childbirth, and the puerperium, should be used first, followed by the appropriate HIV code.

1.1.3 Encounter for testing for HIV

If the results of the test are positive follow the guidelines above. See guidelines 21.2.1 and 21.2.11 for coding of encounters for testing and counseling.

1.2 Sepsis

Sepsis refers to an infection due to any organism that triggers a systemic inflammatory response, the systemic inflammatory response syndrome (SIRS). All codes with sepsis in the title include the concept of SIRS. For cases of sepsis that do not result in any associated organ dysfunction, a single code for the type of sepsis should be used.

For other infections in which SIRS is present but sepsis is not in the code title, code R65.1, Systemic inflammatory response syndrome (SIRS), may also be assigned. For any infection, if associated organ dysfunction is present, a code from subcategory R65.2, Severe sepsis, should be used and the guidelines for coding of severe sepsis should be followed. See guideline 18.2 Severe sepsis and septic shock. Codes for sepsis and septic shock associated with abortion, ectopic pregnancy, and molar pregnancy are in Chapter 15. Code R65.1 and a code from R65.2 should not be used together on the same record.

The terms bacteremia and septicemia NOS are coded to R78.81. If a patient with a serious infection is documented to have septicemia the physician should be asked if the patient has sepsis. If any organ dysfunction is documented the physician should be asked if the patient has severe sepsis. Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition.

The term urosepsis is a non-specific term. If a physician uses the term in a medical record he/she should be asked for which specific condition is the term being used.

1.3 Infectious agents as the cause of diseases classified to other chapters

Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

1.4 Nosocomial infections

If a patient contract an infection while in the hospital, it is necessary to assign code Y95, Nosocomial condition, in addition to the infection code, to identify the infection as nosocomially acquired.

Chapter 2: Neoplasms

2.1 Neoplasm Table

Chapter 2 of the ICD-10-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, are found in the specific body system chapters. To properly code a neoplasm, it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or, of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

The Index for the ICD-10-CM has a separate Table of Neoplasms. It should be used to select the correct code(s). If the histology (cell type) of the neoplasm is documented, that term should be referenced first, in the main section of the Index, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates "adenocarcinoma," refer to the term in the Index to review the entries under this term and the instructional note to "see also neoplasm, by site, malignant." The Neoplasm Table provides the proper code based on the histology of the neoplasm and the site. It is important to select a code from the proper column of the Neoplasm Table that corresponds to the histology of the neoplasm. The Tabular List should then be referenced to verify that the correct code has been selected and that a more specific site code does not exist.

2.2 Use of pathology report

A malignant neoplasm code should not be assigned at the time of initial diagnosis without a pathology report on the record confirming the histologic type of the neoplasm. If the pathology report is not on the record, confirmation of the diagnosis by the attending physician should be documented. A pathology report is not required for confirmed cases, such as encounters for chemotherapy or radiation therapy.

2.3 Morphology codes

Though the Neoplasm Table provides codes based on the histologic type, it only distinguishes between in-situ, benign, malignant or "of uncertain behavior." A secondary morphology code is needed to specifically identify the histologic type of the tumor. A morphology code should be included on a medical record that has a neoplasm diagnosis whenever possible. The morphology codes are found in a separate section of the classification. The proper morphology code can be located in the Index under the term for the histology of the neoplasm.

2.4 Neoplasms of uncertain behavior versus neoplasms of unspecified behavior

A neoplasm of uncertain behavior (Categories D37-D48) is one which after histologic examination is unable to be classified as malignant or benign. The pathologic interpretation is that the cell type cannot be determined.

A neoplasm of unspecified behavior (Category D49) code is only used when there is no documentation in the record indicating the nature of the neoplasm. The unspecified behavior code should not be used if any histologic examination has been made of the excised or biopsied tissue.

2.5 Sequencing of neoplasm codes

If the reason for the encounter is for diagnosis of a suspicious lump, skin lesion, or other indication that a malignancy might be present assign the code for the sign or symptom until confirmation of the diagnosis is made. At the time of coding, if confirmation of a malignancy has been made for an outpatient visit, the neoplasm code should be assigned.

If the reason for the encounter is for treatment of the primary neoplasm, assign the neoplasm as the principal/first listed diagnosis. The primary site is to be sequenced first, followed by any metastatic sites.

When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first listed diagnosis. The primary malignancy is coded as an additional code.

When an encounter is for management of a complication associated with the malignancy, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the malignancy. An exception to this is anemia due to a neoplasm. Code D63.0, Anemia in neoplastic disease, is a manifestation (secondary) code. Coding conventions require that it be sequenced after the underlying neoplasm code.

When an encounter is for a pathological fracture due to a malignancy, if the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture of bone in neoplastic disease, should be sequenced first, followed by the code for the malignancy. If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture. The "code also" note at

M84.5 provides this sequencing instruction.

When an encounter is for pain management due to the malignancy, the pain code, R52.02, R52.12, or, R52.22 should be sequenced first, followed by the appropriate neoplasm code(s). See guideline 18.3 Encounter for pain management.

When the encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of a malignancy, designate the complication as the principal/first-listed diagnosis if treatment is directed at resolving the complication.

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of primary and secondary malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site(s) is coded as a secondary malignant neoplasm to the metastatic site(s). The secondary site may be the principal/first listed with the Z85 code used as a secondary code. See guideline 21.2.12 History (of).

When a primary malignancy has been excised but further treatment, such as an additional surgery, radiation therapy or chemotherapy is directed to that site, the primary malignancy code, not the Z85 code should be used until treatment is completed.

2.6 Cancer in a pregnant patient

Codes from chapter 15, Pregnancy, childbirth, and the puerperium, are always sequenced first on a medical record. A code from subcategory O94.1-, Malignant neoplasm complicating pregnancy, childbirth, and the puerperium, should be used first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

2.7 Malignant neoplasm without specification of site

Code C80, Malignant neoplasm without specification of site, equates to Cancer, unspecified. It is also for disseminated cancer for which no primary site is found. This code should only be used when no determination can be made as to the primary site of a malignancy. It should not be used in place of assigning codes for the primary site and for all known secondary sites.

2.8 Encounters for chemotherapy and radiation therapy

When an encounter involves the surgical removal of a neoplasm, primary or secondary site, followed by chemotherapy or radiation treatment, the neoplasm code should be assigned as the principal/first-listed diagnosis.

If an encounter is solely for the administration of chemotherapy or radiation therapy code Z51.0, Encounter for radiotherapy session, or Z51.1, Encounter for chemotherapy session for neoplasm, should be the principal/first listed code. If a patient receives both chemotherapy and radiation therapy both codes should be listed, in either order of sequence.

When an encounter is for the purpose of radiotherapy or chemotherapy and the patient develops complications such as uncontrolled nausea and vomiting or dehydration, the principal/first-listed code remains the radiation therapy or chemotherapy code. The complications of the treatment should be added as additional codes.

When an encounter is to determine the extent of the malignancy, or for a procedure to treat the malignancy, the primary malignancy or appropriate metastatic site is designated as the principal/first-listed diagnosis, even if chemotherapy or radiotherapy is administered.

When an encounter is for management of the complication of chemotherapy or radiation therapy, and the only treatment is for the complication, the complication is sequenced first followed by the appropriate code(s) for the malignancy.

Due to the potentially toxic nature of many chemotherapy agents certain tests may be performed prior to the administration of chemotherapy as well as during the course of the chemotherapy treatment. The malignancy should be coded as the principal diagnosis for encounters for these tests. The code for long-term (current) use of drug, Z79.82, should be used as a secondary code if the test is being done during the course of chemotherapy treatment.

2.9 Endocrine therpy
Endocrine therapy, such a Tamoxifen, may be given prophylactically, for women at high-risk of developing breast cancer. It may also be given during cancer treatment as well as following treatment to help prevent recurrence. The use of endocrine therapy does not affect the guidelines for coding of neoplasms.

Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism

3.1 Intraoperative and postprocedural hematologic and immune system complications- see guideline 19.3.5.4. Complications of care within body system chapters

Chapter 4: Endocrine, nutritional, and metabolic diseases

4.1 Diabetes mellitus
The Diabetes mellitus (DM) codes are combination codes that include the type of DM, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular visit.

There are 6 DM categories in the ICD-10-CM:
E08, Diabetes mellitus due to underlying condition
E09, Drug or chemical induced diabetes mellitus
E10, Type 1 diabetes mellitus

E11, Type 2 diabetes mellitus
E13, Other specified diabetes mellitus
E14, Unspecified diabetes mellitus

Definitions for the types of DM are a component of the Includes notes under each DM category in the Tabular List. The concepts of insulin and non-insulin requiring diabetes mellitus are not a component of the DM categories in the ICD-10-CM. An additional code, Z79.5, Long-term (current) use of insulin, may be added to identify the use of insulin for diabetic management for categories E08-E09 and E11-E14.

Sequencing of diabetes codes from categories E08 and E09 are based on the convention found at each category. Categories E08 and E09 have a "code first" note indicating that the diabetes code is to be sequenced after the underlying condition, drug or chemical, that is responsible for the diabetes. Codes from categories E10-E14 are sequenced first, followed by codes for any additional complications outside these categories, if needed.

4.1.1 Diabetes mellitus in a pregnant patient
Codes from Chapter 15, Pregnancy, childbirth, and the puerperium, are always sequenced first on a medical record. A pregnant woman with pre-existing DM should be assigned a code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, first, followed by the appropriate diabetes code from Chapter 4. For women who develop diabetes during pregnancy, see guideline 15.7, Gestational diabetes.

4.1.2 Diabetic patients who receive an organ(s) transplant
Patients who receive a new pancreas for treatment of their DM may no longer require insulin or other care for their DM, but pre-existing complications from the DM may still exist after transplant. Codes from the DM categories are still applicable to describe the complications in such cases. A transplant status code should be used with the diabetes code in these cases.

4.2 Intraoperative and postprocedural endocrine system complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 5: Mental and behavioral disorders

5.1 ICD-10-CM and DSM-IV-TR
The codes in Chapter 5 parallel, in most cases, the codes found in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV TR) published by the American Psychiatric Association. For definitions of the psychiatric terms and conditions used in this chapter, reference the DSM-IV TR. Selection of the proper code from Chapter 5 should be based solely on the terminology and documentation found in the medical record.

5.2 Alcohol and drug abuse and dependence
The drug and alcohol codes are multiaxial, combination codes that identify the substance, the

type of use, abuse or dependence, and the complications and manifestations caused by the substance. The category level is the substance, such as, alcohol (F10) and other types of drugs, (F11-F19), including nicotine, (F17). The 4th character axis distinguishes abuse or dependence. The 5th and 6th characters indicate the complication, such as withdrawal or delusions. The types of complications and manifestations at the 5th and 6th character are specific to the type of drug.

Multiple codes from a single category from categories F10-F19 may be used together, if a patient has multiple complications from a single substance. Multiple codes from different categories from F10-F19 may be used together, if a patient has used more than one substance and has multiple complications associated with the use of the substances.

An additional code from category Y90, Evidence of alcohol involvement determined by blood alcohol level, should be used with a code from F10, Alcohol-related disorders, if the patient's blood alcohol level is recorded. A code from Y90 should be recorded only once, at the initial blood alcohol level reading.

Codes from the poisoning and toxic effects section of Chapter 19 (T40, T51) should be used in conjunction with the F10-F19 codes if a patient has an acute alcohol or drug poisoning or overdose, even if the patient is dependent on alcohol or drugs. See guideline 19.3.2 Poisonings, toxic effects, adverse effects and underdosing.

5.3 Dementia with behavioral disturbance

Category F02, Dementia in other diseases classified elsewhere, is a manifestation category that is for use with codes for specific types of dementia, such as Alzheimer's disease (G30). The code for the specific type of dementia is sequenced first, followed by the appropriate code from category F02. The code from category F02 indicates whether the dementia has an associated behavioral disturbance.

Chapter 6: Diseases of nervous system

6.1 Dominant/nondominant side

For patients with hemiplegia and other paralytic syndromes the side involved is important in determining potential for recovery. Patients whose dominant side is affected will have a more difficult time with rehabilitation than patients whose nondominant side is affected. Generally, the patient's dominance is recorded in the initial history and physical. If there is reference to a patient being right-handed or left-handed this indicates dominance. Dominance is present in both the upper and lower limbs.

Codes from category G81, Hemiplegia and hemiparesis, and subcategories, G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, have a final character for dominant and nondominant side. Should this information not be available in the record, the default should be dominant. For ambidextrous patients, the default should also be dominant.

6.2 Parkinson's disease
There are 2 categories in the ICD-10-CM for Parkinson's disease, G20, Parkinson's disease and G21, Secondary parkinsonism. G20 is the code for primary Parkinson's disease. It is the default code for the condition.

G21, Secondary parkinsonism, is a result of another condition such as an encephalitis or poisoning. The symptoms of Parkinson's disease develop secondary to the initial condition. The sequencing of a code from G21 is based on the conventions found at the G21 codes.

The shakes and tremors associated with Parkinson's disease are also symptoms of a form of dementia, dementia with Lewy bodies (G31.83). The term dementia with Parkinsonism is included under code G31.83. G31.83 is excluded from G21.

6.3 Dementia
Two codes are required for dementia. First the dementia code, followed by a secondary code from category F02 for the behavioral component of the dementia. See guideline 5.3 Dementia with behavioral disturbance.

Cases of dementia are often diagnosed strictly by the symptoms and behavior of the patient. For certain types of dementia confirmation of the diagnosis can only be made at autopsy. For this reason physicians often document probable or suspected dementia. Dementia is one group of conditions where it is acceptable to code the condition even if it is stated as probable or suspected.

6.4 Intraoperative and postprocedural nervous system complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 7: Diseases of the eye and adnexa

7.1 Laterality
For most of the categories in Chapter 7 there are codes for right eye, left eye, and bilateral. In cases where a code does not provide a designation for which eye is involved, that condition is always bilateral. In cases where a bilateral code is not provided the condition is always unilateral.

7.2 Intraoperative and postprocedural ophthalmologic complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 8: Diseases of the ear and mastoid process

8.1 Intraoperative and postprocedural auditory system complications- See guideline 19.3.5.4. Complications of care within the body system chapters.

Chapter 9: Diseases of circulatory system

9.1 Rheumatic heart disease
The default for the coding of certain heart valve disease is rheumatic. However, if there is no documentation in the medical record that a patient has had rheumatic fever, the non-rheumatic code should be assigned.

9.2 Hypertension

9.2.1 Hypertensive heart disease
The codes in category I11, Hypertensive heart disease, are combination codes that include both hypertension and heart disease. The "Includes" note at I11 specifies the conditions that are included with I11. If a patient has both a condition listed in the "Includes" note and hypertension then a code from I11 should be used, not individual codes for hypertension and heart disease. No causal relationship needs to be documented.

The final character of the codes identifies with and without heart failure. The default is without heart failure. For code I11.0, Hypertensive heart disease with heart failure, a secondary code from category I50, Heart failure, is required to identify the type of heart failure.

9.2.2 Hypertensive renal disease
The codes in category I12, Hypertensive renal disease, are combination codes that include both hypertension and renal disease. The "Includes" note at I12 specifies the conditions that are included with I12. If a patient has both a condition listed in the "Includes" note and hypertension then a code from I12 should be used, not individual codes for hypertension and renal disease. No causal relationship needs to be documented.

The final character of the codes identifies with or without chronic renal failure. The default is without chronic renal failure. If a patient has hypertension with both acute and chronic renal failure, an additional code for the acute renal failure is required.

9.2.3 Hypertensive heart and renal disease
The codes in category I13, Hypertensive heart and renal disease, are combination codes that include hypertension, heart disease and renal disease. The Includes note at I13 specifies that the conditions included at I11 and I12 make up I13. If a patient has hypertension, heart disease and renal disease then a code from I13 should be used, not individual codes for hypertension, heart disease and renal disease, or codes from I11 or I12.

For patients with heart failure a secondary code from category I50, Heart failure, is required. For patients with both acute and chronic renal failure an additional code for acute renal failure is required.

9.2.4 Hypertensive retinopathy
Code H35.0, Hypertensive retinopathy, may be used alone, or with code I10, Essential (primary) hypertension, to include the systemic hypertension. If both codes are used the sequencing is based on the reason for the encounter.

9.2.5 Secondary hypertension
Secondary hypertension is due to an underlying condition but category I15, Secondary hypertension, is not a manifestation (paired) category. Two codes are required when assigning a code from I15, one to identify the underlying etiology and one from category I15 to identify the hypertension. The sequencing of the codes is based on the reason for the encounter.

9.2.6 Hypertension, controlled
This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign code I10.

9.2.7 Hypertension, uncontrolled
Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, it should be coded as hypertension.

9.2.8 Elevated blood pressure
For a statement of elevated blood pressure without further specificity, assign code R03.0, Elevated blood-pressure reading, without diagnosis of hypertension, rather than code I10. R03.0 is also for use for a single elevated blood pressure reading or for transient elevated blood pressure.

9.3 Atherosclerotic coronary artery disease and angina
ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris. The codes identify the type of angina.

When using a combination code it is not necessary to use an additional angina pectoris code. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis. The angina does not have to be documented to be due to the specified occluded artery.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease. See guideline 9.4 Initial and subsequent acute myocardial infarction (AMI)

9.4 Initial and subsequent acute myocardial infarction (AMI)

The ICD-10-CM has two categories for acute myocardial infarction, I21, Acute myocardial infarction and I22, Subsequent acute myocardial infarction. The I21 is for all cases of initial myocardial infarction. A code from I21 is to be used from onset of the AMI until 4 weeks following onset. The 4 week period is considered the length of time needed for healing.

A code from I22 is to be used if a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial MI. A code from category I22, Subsequent myocardial infarction, must be used in conjunction with a code from category I21, Acute myocardial infarction.

The sequencing of the I22 and I21 codes depends on the circumstances of the encounter. Should a patient who is in the hospital due to an AMI have a subsequent AMI while still in the hospital, the I21 would be sequenced first as the reason for admission with the I22 code sequenced as a secondary code. Should a patient have a subsequent AMI after discharge for care of an initial AMI and the reason for admission is the subsequent AMI, the I22 code should be sequenced first followed by the I21. The I21 must accompany the I22 to show the site of the initial AMI and to indicate that the patient is still within the 4 week time frame of healing from the initial AMI.

When both an AMI and atherosclerotic coronary artery disease are documented in a medical record the AMI is to be sequenced first followed by a code for the coronary artery disease. This sequencing is based on the acute life-threatening condition being the principal reason for admission. Though treatment of the AMI is directed at relieving the occlusion caused by the underlying coronary artery disease, the majority of adults have some amount of atherosclerotic plaque in their coronary arteries. It is only when the atherosclerosis is severe enough to obstruct blood flow to the heart that an AMI occurs, necessitating immediate attention. When coding atherosclerotic coronary artery disease with an AMI the appropriate coronary artery disease combination code for "with unstable angina" should be used.

9.5 Cardiac arrest

There are three codes under category I46, I46.2, Cardiac arrest due to underlying cardiac condition, I46.8, Cardiac arrest due to other underlying condition, and I46.9, Cardiac arrest, cause unspecified.

I46.9, Cardiac arrest, cause unspecified, is acceptable as a principal diagnosis only if the patient expires or is discharged within 24 hours of admission to the hospital or the emergency department and no determination is made as to the cause of the cardiac arrest. Though a cardiac arrest qualifies as an emergent, life-threatening condition, it is considered a non-specific principal diagnosis. Code I46.9 should not be used as a secondary diagnosis unless the cause of the arrest is undocumented.

I46.2, Cardiac arrest due to underlying cardiac condition, and I46.8, Cardiac arrest due to other underlying condition, may be used as secondary diagnoses when a patient with an underlying condition suffers an arrest while under care for the underlying condition. These codes should never be used as the principal diagnosis since their use indicates that the underlying cause is known.

Should attempts be made to resuscitate a patient who suffers a cardiac arrest a code from I46 should be used regardless of whether the resuscitation is successful or not. The procedure code on the record will indicate that a resuscitation attempt was performed.

9.6 Cerebrovascular occlusion and stenosis and cerebral infarction

There are three categories in ICD-10-CM for occlusion and stenosis of the precerebral and cerebral arteries that incorporate the presence or absence of cerebral infarction. Category I63, Cerebral infarction, identifies the site and type of the infarct at the 4th character level. Category I65, Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction, and Category I66, Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction, are for use when there is evidence of obstruction of a vessel but there is no resulting evidence of an infarct.

A code from I65 and I66 should not be used with a code from I63 of the same artery. A code from I65 and I66 may be used with a code from I63 if a patient has both an infarction of one artery and occlusion of other arteries. It is often difficult to determine the site of a cerebral infarction in a patient with extensive cerebrovascular disease. Documentation in the record and consultation with the physician, if necessary, is required to determine the correct code or codes from the I63, I65, and I66 categories. Code I63.9, Cerebral infarction, unspecified, may be used if an infarction is documented but no artery is specified.

9.7 Stroke, not specified as hemorrhage or infarction

Code I64, Stroke, not specified as hemorrhage or infarction, is the generic, non-specific code for a cerebrovascular accident (CVA). It is only for use in limited circumstances when no documentation is available indicating the type of stroke. When documentation exists, a code for a cerebral infarction or hemorrhage should be used, not I64. See guideline 9.8 Sequelae of cerebrovascular disease.

9.8 Sequelae of cerebrovascular disease

Category I69, Sequelae of cerebrovascular disease, is for use to classify the complications of intracerebral hemorrhage and infarction. Codes from I69 can be used as soon after the initial cerebrovascular accident as sequelae appear. Codes under I69 include the site and type of the CVA at the subcategory level, the fifth character identifies the sequelae and the 6th character identifies the side of the body affected. As many codes as are necessary to identify all of the sequelae may be used.

A code from I69 may be used in conjunction with a current cerebral hemorrhage or infarction code if a patient has a current hemorrhage or infarction of either the same site or of a different site at the same time as the sequelae.

9.9 Intraoperative and postprocedural circulatory system complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 10: Diseases of respiratory system

10.1 Chronic obstructive pulmonary disease (COPD)
The ICD-10-CM category for chronic bronchitis is J42, for emphysema J43, for chronic obstructive pulmonary disease (COPD), J44, and for asthma, J45.

If a patient has a single condition, either chronic bronchitis, emphysema or asthma, a single code from the appropriate category should be used.

For a patient who has a combination of chronic obstructive lung problems, a single code from category J44 is usually appropriate. The following combination of conditions, stated as such in the medical record, are included under category J44:

asthma with chronic obstructive pulmonary disease
chronic bronchitis with airway obstruction
chronic bronchitis with emphysema
chronic emphysematous bronchitis
chronic obstructive asthma
chronic obstructive bronchitis
chronic obstructive tracheobronchitis

Only these combinations are included in category J44 . Any combinations not included must be coded with individual codes.

The codes in category J44, Other chronic obstructive pulmonary disease, indicate whether a patient has an uncomplicated case, an acute exacerbation or a co-existing acute lower respiratory infection. The code for the acute lower respiratory infection takes precedence over the acute exacerbation. If the infection is a pneumonia or influenza, a secondary code for the type of pneumonia or the influenza is also needed.

10.2 Nosocomial respiratory infections
If a patient contract a respiratory infection while in the hospital, it is necessary to assign code Y95, Nosocomial condition, in addition to the infection code, to identify the infection as nosocomially acquired.

10.3 Intraoperative and postprocedural respiratory system complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 11: Diseases of digestive system

11.1 Ulcers
All of the codes under ulcer categories, K25, Gastric ulcer, K26, Duodenal ulcer, K27, Peptic ulcer, site unspecified, and K28, Gastrojejunal ulcer, have combinations codes that identify complications of the ulcer, (bleeding, and perforation). No secondary complication codes are needed when using one of the combination codes for ulcers. Multiple codes from each category may be used if a patient has multiple complications.

11.2 Crohn's disease/ulcerative colitis
The codes under subcategories K50, Crohn's disease, and K51, Ulcerative colitis, identify a single complication of the conditions. Should a patient have multiple complications, multiple codes from K50 or K51 may be used to identify each of the complications.

11.3 Intraoperative and postprocedural digestive system complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 12: Diseases of the skin and subcutaneous tissue

12.1 Dermatology codes and use of an external cause
For categories L56, Other acute skin changes due to ultraviolet radiation, and L57, Skin changes due to chronic exposure to nonionizing radiation, a secondary external cause code identifying the source of the exposure should be used.

For codes L56.0, Drug phototoxic response, and L56.1, Drug photoallergic response, and all other codes that identify a dermatologic condition due to a drug or chemical, a code from categories T36-T50, Poisoning and adverse effects of drugs, medicaments and biological substances, and T51-T65, Toxic effects of substances chiefly nonmedicinal as to source, is to be sequenced first, to identify the drug or chemical, followed by the dermatology code. See guideline 19.3.2 Poisoning, toxic effects, adverse effects and underdosing.

No external cause code is needed for category L55, Sunburn.

12.2 Decubitus ulcers and non-decubitus chronic ulcers of lower limb codes
The codes in categories L89, Decubitus ulcer, and L97, Non-decubitus chronic ulcer of lower limb, not elsewhere classified, contain a great deal of detail. The 5th character of the codes identifies the specific site of the ulcer. The 6th character identifies the depth of the ulcer. When assigning a code for these ulcers it is important to review the record thoroughly to verify both the site and severity of the ulcer. For multiple ulcers of the same site, it is only necessary to assign a code for the most severe ulcer.

The sequencing instructions at categories L89 and L97 differ slightly from the standard conventions. Decubitus ulcers may occur at multiple sites. A decubitus ulcer that has become

very serious and does not respond to treatment may be the reason for admission to a hospital. The decubitus ulcer should be the principal diagnosis if it is the reason for admission. Secondary codes for the other health problems associated with the decubitus ulcer should also be assigned.

Generally, an underlying condition is responsible for a non-decubitus ulcer of the lower limb (L97.-). Any condition that reduces blood flow to the legs may cause a lower limb ulcer. The same condition may also prevent healing of the ulcer even with aggressive treatment. When the underlying condition is known, the underlying condition should be sequenced before the ulcer. Atherosclerosis of the lower extremities and diabetes mellitus are commonly the underlying conditions responsible. Combination codes for atherosclerosis of the lower extremities and diabetes mellitus include lower extremity ulcers. A code from L97 to specify the site and depth of the ulcer is needed with the combination code for the underlying condition. In some cases no underlying cause is documented to be responsible for the ulcer. In such cases a code from L97 may be principal or first listed. The instructional note at L97 indicates that the "code first" note is applicable only when an underlying condition is documented.

Both decubitus and non-decubitus ulcers may become so severe that gangrene sets in at the site of the ulcer. For cases of gangrene resulting from a skin ulcer, the gangrene should be sequenced first, followed by the code for the ulcer. Gangrene is necrosis of the tissue. When gangrene is present, the primary focus of treatment is to remove the gangrene, usually with debridement or amputation of the affected area. The "code first" note at categories L89 and L97 instructs that gangrene is to be sequenced before the ulcer. This note applies only if gangrene is present.

12.3 Intraoperative and postprocedural dermatologic complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 13: Diseases of the musculoskeletal system and connective tissue

13.1 Site and laterality
Most of the codes within Chapter 13 have site and laterality designations. The site represents either the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, there is a multiple site code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

The site designations for the limbs are upper arm, lower arm, upper leg and lower leg, (humerus, radius and ulna, femur, tibia and fibula). When a condition is described as of the arm or leg, without indicating upper or lower, then the code for upper arm or lower leg should be used.

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

13.2 Acute/chronic/recurrent musculoskeletal conditions
Many of the conditions in chapter 13 are a result of previous injury or trauma to a site, or are recurrent conditions. Any current, acute injury should be coded to the appropriate injury code. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, confer with the physician.

13.3 Osteoporosis
There are 2 categories for osteoporosis, M80, Osteoporosis with current pathologic fracture, and M81, Osteoporosis without current pathologic fracture. Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. For this reason, site codes are not provided for codes M81.0, Postmenopausal osteoporosis without current pathological fracture, and M81.8, Other osteoporosis without current pathological fracture.

M81 is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.31, Personal history of osteoporosis fracture, should accompany the code from M81.

Category M80 is for a patient who has a current pathologic fracture at the time of the encounter. The codes under M80 identify the site of the fracture. A pathologic fracture code, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

13.4 Intraoperative and postprocedural musculoskeletal system complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

13.5 Pathologic fracture in neoplastic disease- See guideline 2.5 Sequencing of neoplasm codes.

Chapter 14: Diseases of the genitourinary system

14.1 Renal failure
There are two categories for renal failure in ICD-10-CM, N17, Acute renal failure (ARF), N18, Chronic renal failure (CRF), and code N19, Unspecified renal failure. N19 is a nonspecific code that should rarely be used in the inpatient setting. Uremia NOS is included under N19. If the term uremia is documented in a medical record, the physician should be asked for a more precise diagnosis.

ARF, though a serious condition that is life-threatening if left untreated, is generally a result of an underlying condition that is affecting kidney function. Correction of the underlying condition restores normal kidney function. The “code also” note at N17 instructs that ARF may be either a

principal diagnosis or secondary code. The diagnosis of ARF indicates that the underlying condition is causing a serious problem and requires immediate attention. Sequencing is based on the severity of the underlying condition and the primary focus of treatment. ARF is always the result of another condition so, regardless of the sequencing it should never be the single condition coded on a record. A code from N17 should always have an accompanying code for the causal condition.

Dehydration and urinary obstruction are two common conditions that may cause ARF. Generally, rehydrating the patient and relieving the obstruction is adequate to correct the ARF. For these types of conditions the ARF should be sequenced before the underlying condition if it is the focus of treatment. Otherwise, the underlying condition should be sequenced first.

When the underlying condition is serious in itself and treatment is directed at the underlying condition, the underlying condition should be sequenced before ARF. An example of this is severe sepsis. It is life-threatening and treatment is directed at correcting all of the organ dysfunctions for which it is responsible. ARF is just one of many serious complications that may result from severe sepsis. Severe sepsis should be coded before any of the organ dysfunction codes, including ARF.

CRF is a non-reversible malfunctioning of the kidneys that results from conditions such as chronic hypertension and diabetes mellitus or from certain drugs or chemicals that damage the kidneys. Treatment for CRF is generally regular hemodialysis or peritoneal dialysis. CRF is not generally a reason for an inpatient admission except for patients admitted for kidney and other organ transplant. For patients receiving dialysis or care associated with dialysis in any setting, a code from category Z49, Encounter for care involving renal dialysis, should be the first listed code followed by a code from N18.

When a combination code exists for a condition that includes the CRF, such as diabetes mellitus with renal complications or hypertensive renal disease a second code from N18 is not needed.

14.2 Infertility

Codes for male infertility (N46) are not for use on a female record, even if a woman is receiving assisted reproductive therapy due to male partner infertility. Code Z31.81, Encounter for male factor infertility in female patient, is for use on a female record for these situations. Additional codes may be used in conjunction with Z31.81 to fully describe the encounter for assisted reproductive therapy.

14.3 Hyperplasia of prostate

The codes in category N40, Hyperplasia of prostate, are combination codes that include both the condition of the prostate and the associated complications, such as obstruction and hematuria. When using a code from category N40, it is not necessary to add secondary codes for the associated complications that are included in the codes.

14.4 Hypertensive renal disease- See guideline 9.2.2 Hypertensive renal disease.

14.5 Intraoperative and postprocedural genitourinary system complications- See guideline 19.3.5.4 Complications of care within the body system chapters.

Chapter 15: Pregnancy, childbirth and the puerperium

15.1 General Chapter 15 Guidelines
Codes from Chapter 15 take sequencing precedence over codes from all other chapters. Regardless of any other condition a pregnant woman may have, the appropriate obstetric (OB) code is to be sequenced first, followed by codes for the co-existing conditions.

Code Z33.1, Pregnant state, incidental, should only be used in rare instances. Any co-existing condition occurring during pregnancy should be considered a complication of the pregnancy unless expressly documented in the record that it is not affecting the pregnancy.

There are combination OB codes for conditions from all other chapters of the classification, including neoplasms and trauma. The OB combination code may not include as much detail as the code from the body system chapter. "Use additional code" notes are found at many Chapter 15 categories indicating that a secondary code is needed to provide more detail on the condition(s) from other chapters that are affecting the pregnancy.

Codes from Chapter 15 are for use only on the maternal record, never on the record of a newborn.

Codes in Chapter 15 represent only the diagnosis or reason for encounter. All procedures resulting from conditions found in Chapter 15, including delivery, must be indicated with a procedure code.

15.2 Sequencing of obstetric (OB) codes
The first OB code assigned should be based on the most significant reason for the encounter. For encounters when no delivery occurs, the first assigned diagnosis should correspond to the most significant complication of the pregnancy, which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.

When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery.

In encounters with a cesarean delivery, the selection of the principal diagnosis should correspond to the reason the cesarean delivery was performed, unless the reason for the encounter was unrelated to the condition resulting in the cesarean delivery.

15.3 Trimesters

The majority of codes in Chapter 15, beginning with category O09, have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If no trimester character is provided for a specific code in a category, it is because the condition always occurs in a specific trimester, or the trimester is not applicable, such as a postpartum condition. An example of this is gestational diabetes. It only occurs in late pregnancy. Certain codes have characters for only certain trimesters, not all three, because the condition does not occur in all trimesters, but it may occur in more than just one.

Each category that includes codes for trimester has a code for "unspecified trimester." The "unspecified trimester" code is never to be used, unless it is impossible to determine the trimester of the pregnancy from the documentation in the record.

For a patient who enters the hospital for complications of pregnancy and remains in the hospital for antepartum complications, delivery, and postpartum complications, it is acceptable to use the final character that corresponds to the trimester of the occurrence of the complication. It is acceptable to use codes indicating different trimesters of pregnancy as well as postpartum on the same record.

15.4 Complications of ectopic pregnancy, miscarriage and other abnormal products of conception

Complications of ectopic pregnancies, category O00, hydatidiform mole, category O01, other abnormal products of conception, category O02 and spontaneous abortion, category O03, require a code from category O08, Complications following ectopic and molar pregnancy to identify the complication. Should an encounter be for the complication itself, after the initial encounter for the pregnancy, a code from O08 should be the first listed code with no code from O00-O03.

Any procedure required for these conditions, such as the removal of retained products of conception, requires a procedure code from the appropriate procedure classification.

15.5 Multiple gestations

Chapter 15 has extensions for multiple gestations. An extension must be added to any code from Chapter 15 in which there is a multiple gestation pregnancy, indicating which fetus is affected by the particular condition being coded. Each fetus must be given an extension designation and this designation must be documented in the record so that the appropriate code(s) may be assigned consistently to the correct fetus.

An ectopic pregnancy (category O00) occurring with an intrauterine pregnancy is considered a multiple gestation. Both the ectopic pregnancy and the intrauterine pregnancy should be assigned an extension. Any complication code for the ectopic pregnancy (category O08) should have the same extension as the code from O00. All codes for the intrauterine pregnancy should have the same extension to distinguish them from the ectopic pregnancy codes.

15.6 HIV in a pregnant patient

During pregnancy, childbirth or the puerperium, a patient with HIV infection or an HIV-related illness should be assigned code O98.7, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by the appropriate code(s) for the HIV disease. See guidelines 1.1.2 HIV in a pregnant patient.

15.7 Gestational diabetes

Codes for gestational (pregnancy-induced) diabetes are in subcategory O24.4. No other code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4. If a patient with gestational diabetes is treated with both diet and insulin, the default is for insulin-controlled.

15.8 Pre-existing conditions versus conditions due to the pregnancy

Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy and those that are a direct result of pregnancy. When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.

Category O09, Supervision of high-risk pregnancy, includes codes for patients who have had complications with pregnancy in the past. Codes from this category may be used with other codes from Chapter 15.

O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, and O11, Pre-existing hypertensive disorder with superimposed proteinuria, are for cases when a pregnant woman has hypertension prior to pregnancy. Categories O12, Gestational [pregnancy-induced] edema and proteinuria without hypertension, O13, Gestational [pregnancy-induced] hypertension without significant proteinuria, and O14, Gestational [pregnancy-induced] hypertension with significant proteinuria, are for pregnancy-related conditions. Similarly, there are codes for pre-existing diabetes mellitus complicating pregnancy, O24.0-O24.3, and O24.8 and for gestational diabetes, O24.4.

Category O94, Maternal malignant neoplasm, traumatic injuries and abuse classified elsewhere but complicating pregnancy, childbirth and the puerperium, may be used for conditions that are pre-existing but will most often be used for cases when a malignancy is diagnosed or an injury occurs during pregnancy (See guideline 19.3.4.2 for instructions on coding of abuse in pregnancy). Categories O98, Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium, and O99, Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium, will most often be assigned for pre-existing conditions, but may be used for conditions diagnosed during pregnancy. Subcategory O99.0, Anemia complicating pregnancy, childbirth and the puerperium, is only for use for pre-existing anemia. Postpartum anemia is coded O90.81. Anemia following delivery is very common in women who were not anemic before or during pregnancy due to the blood loss associated with delivery.

Pregnancy associated cardiomyopathy (O09.3) is unique in that it may be diagnosed in the third trimester of pregnancy but may continue to progress months after delivery. For this reason, it is referred to as peripartum cardiomyopathy. Mortality from this complication is very high. Heart transplantation may be the only treatment option. Code O09.3 is only for use when the cardiomyopathy develops as a result of pregnancy in a woman who did not have pre-existing heart disease.

Categories that do not distinguish between pre-existing and pregnancy-related conditions may be used for either. It is acceptable to use codes specifically for the puerperium with codes complicating pregnancy and childbirth if a condition arises postpartum during the delivery encounter.

15.9 Maternal care for fetal conditions

Categories O35, Maternal care for known or suspected fetal abnormality and damage, and O36, Maternal care for other fetal problems, are for problems with the fetus that affect the management of the pregnancy. Codes from these categories may be used for suspected problems with the fetus that have not been confirmed, as it is often not possible to confirm a fetal abnormality in utero.

15.10 Fetal care

Category O37, Fetal care for fetal abnormality and damage, is for use if treatment, such as a surgical procedure, is done to the fetus itself, in utero, or for complications of such treatment. Codes from this category are for use on the maternal record, or, on a fetal record, if an institution creates a unique record for the fetus. Category O37 is not for use on the record of a newborn.

Codes from Chapter 16, Certain conditions originating in the newborn (perinatal) period, are not for use on a mother's record. Perinatal codes are only for use on a newborn or infant record. They are not to be assigned to describe abnormalities of a fetus.

15.11 Outcome of delivery

A code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred to indicate the status of the baby/babies born. These codes are not to be used on subsequent maternal records or on the newborn record.

15.12 Intrauterine death versus stillbirth

An intrauterine death is assigned either code O02.1, Missed abortion, for early fetal deaths before 20 weeks of gestation, or O36.4, Maternal care for intrauterine death, for late fetal deaths after 20 weeks of gestation. These codes are for use on the mother's record.

P95, Stillbirth, is only for use on a record designated for the baby. P95 is never for use on a maternal record.

A stillbirth code from category Z37, Outcome of delivery, is only for use on the record of a mother's delivery encounter, to indicate the status of the baby born. It is not for use with code P95.

15.13 Encounter for full-term uncomplicated delivery

Code O80, Encounter for full-term uncomplicated delivery, is for use in cases when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode.

Code O80 may be used if the patient had a complication at some point during her pregnancy but the complication is not present at the time of the admission for delivery.

Code O80 is always a principal diagnosis. It is not to be used if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code O80 if they are not related to or are in any way complicating the pregnancy.

Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O80.

15.14 Encounter for cesarean delivery without indication

O82, Encounter for cesarean delivery without indication, is only for use for a delivery episode when a woman elects to have a cesarean delivery without medical need. It is not for use with any other code from Chapter 15 that would justify a cesarean delivery. It is always a principal diagnosis. It is a reason for encounter code. A procedure code for the cesarean delivery must accompany O82.

Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O82.

15.15 Routine prenatal visits

For routine prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis. Codes from Z34 should not be used with Chapter 15 codes.

15.16 Encounter for termination of pregnancy

A woman being seen for an elective termination of an uncomplicated intrauterine pregnancy should be assigned Z33.2, Encounter for elective termination of pregnancy, as the first listed code.

Any immediate or subsequent complications of the procedure are identified with codes from categories O04, Complications following (induced) termination of pregnancy, or O07, Failed attempted termination of pregnancy.

Should a woman undergo a termination of a pregnancy due to fetal demise, other complications with the fetus or the health of the woman, the complication code(s) from Chapter 15 should be used, not code Z33.2. The termination is indicated with a procedure code.

15.17 The postpartum period

The postpartum period begins immediately after delivery and continues for six weeks following delivery.

A postpartum complication is any complication occurring within the six-week postpartum period.

Chapter 15 codes may also be used to describe pregnancy-related complications after the six-week period, if the physician documents that a condition is pregnancy related.

When a woman delivers outside the hospital prior to admission, and is admitted for routine postpartum care and no complications are noted, code Z39.0, Encounter for care and examination immediately after delivery, should be assigned as the first diagnosis. Should complications be noted, such as lacerations, the appropriate code for the complication from Chapter 15 should be assigned, not code Z39.0.

A delivery diagnosis code should not be used for a woman who has delivered prior to admission to the hospital. No outcome of delivery code should be used for these cases. Any postpartum procedures should be coded.

15.18 Sequelae of complication of pregnancy, childbirth, and the puerperium

Code O93, Sequelae of complication of pregnancy, childbirth, and the puerperium, is for use in those cases when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.

This code may be used at any time after the initial postpartum period.

Code O93 is sequenced following the code describing the sequelae of the complication.

15.19 Encounter for contraceptive and procreative management

Encounters for family planning and counseling, category Z30, Encounter for contraceptive management, and category Z31, Encounter for procreative management, should be included on an obstetric record either during the pregnancy or in the postpartum period, if applicable.

Codes from these categories may also be used for non-pregnant patients who are being seen for family planning and fertility services.

15.20 Encounter for antenatal screening

Code Z36, Encounter for antenatal screening, is for use for routine antenatal screening in pregnant women. Like all screening codes, it is only for use for women in whom no fetal

abnormalities are suspected. It may be used as a reason for visit code, or, in conjunction with other codes from Chapter 15.

Separate procedure codes for any screenings done must also be used.

Chapter 16: Certain conditions originating in the newborn (perinatal) period

16.1 General Chapter 16 guidelines
The perinatal period is defined as birth through the 28th day following birth.

All clinically significant conditions noted on routine newborn examination should be coded, the most serious or the one requiring the most care sequenced first. A condition is clinically significant if it requires:
clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring; or
has implications for future health care needs.

What constitutes a clinically significant condition is the same for perinatal records as for all other records, with the addition of the final point regarding implications for future health care needs.

Codes in this chapter are only for use on the newborn or infant record, not on the maternal record. Codes from this chapter are only applicable for liveborn infants.

Should a condition originate in the perinatal period, and continue throughout the life of the child, the perinatal code should continue to be used regardless of the age of the patient.

In cases where a baby has a condition that may be either due to the birth process (e.g., P35-P39, Infections specific to the perinatal period) or community acquired, the default should be complication of birth and a code from Chapter 16 should be used.

16.2 Liveborn infant according to place of birth and type of delivery
When coding the birth of an infant, assign a code from category Z38, Liveborn according to place of birth and type of delivery. A code from this category is assigned as a principal/first listed diagnosis and assigned only once to a newborn at the time of birth.

If the newborn is transferred to another institution, a code from Z38 is not used at the receiving hospital.

16.3 Newborn (suspected to be) affected by maternal conditions

A newborn may be suspected of having a problem due to a condition of the mother. Tests and treatment may be initiated even if the newborn is not showing obvious signs or symptoms of a problem. Categories P00-P04, Newborn affected by maternal factors and by complications of pregnancy, labor and delivery, are for use in these cases. Codes from these categories are still acceptable for use if any testing or treatment is done, even if no problem with the infant is determined. Should a problem with the baby be confirmed, codes from Chapter 16 to identify the specific condition should be used, followed by a code from the P00-P04 series.

16.4 Congenital anomalies in a newborn

Assign the appropriate code(s) from Chapter 17, Congenital malformations, deformations and chromosomal abnormalities, as additional diagnoses when a specific abnormality is diagnosed for a newborn. See guideline 17.1 Coding of syndromes.

16.5 Prematurity and low birth weight

Codes from category P05, Disorders of newborn related to slow fetal growth and fetal malnutrition, and subcategories P07.0, Extremely low birth weight newborn, and P07.1, Other low birth weight newborn, specify birth weight. Codes from subcategories P07.2, Extreme immaturity of newborn, and P07.3, Other preterm newborn, specify weeks of gestation. For birth weight, select the code that corresponds to the first weight recorded for the newborn. For weeks of gestation, select the code for the number of completed weeks of gestation.

Both birth weight and gestational age are usually documented. Both should be coded, with birth weight sequenced before gestational age. These codes should be used along with all other appropriate codes for the complications of preterm birth or low birth weight. The low birth weight code will normally be the first code following the Z38 unless a particularly serious complication, such as an infection or hemorrhage, receives the primary focus of treatment.

16.6 Low birth weight and immaturity status

Codes from subcategory Z91.7, Low birth weight and immaturity status, are for use as personal status codes for a child or adult who was small as a newborn. See guideline 21.2.6 Status.

16.7 Newborn affected by intrauterine procedure

Code P96.5, Complication to newborn due to (fetal) intrauterine procedure, not elsewhere classified, is for use on the newborn record to indicate that a procedure done on the newborn when he/she was still in utero, caused a complication(s) that is still affecting the newborn. Additional code(s) should be used with P96.5 to identify the complication(s).

16.8 Stillbirth

Code P95, Stillbirth, is only for use for institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother's record. A stillbirth code from category Z37, Outcome of delivery, is only for use on the record of a mother's delivery encounter to indicate the status of the baby born. It is not for use with code

P95.

Chapter 17: Congenital malformations, deformations and chromosomal abnormalities
Codes from Chapter 17 may be used for any patient, regardless of the patient's age. Many of the conditions from this chapter are life-long.

17.1 Coding of syndromes
Congenital anomalies or syndromes may occur as a set of symptoms or multiple malformations. If the syndrome does not have a specific code, a code should be assigned for each presenting manifestation of the syndrome, from any chapter in the classification. For syndromes with specific codes, additional codes may be assigned to identify manifestations not included in the specific code.

Chapter 18: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

18.1 General Chapter 18 guidelines
Codes from Chapter 18 are for use to describe the signs and symptoms that are bringing the patient in for care, and as final diagnoses when no definitive condition has been established at the end of an encounter.

A symptom code should be used with a confirmed diagnosis if the symptom is not always associated with that diagnosis, such as the use various signs and symptom associated with complex syndromes.

Many codes within other chapters of the ICD-10-CM are combination codes that include the diagnosis and the most common symptoms of that diagnosis. When using a combination code, a secondary code for the associated symptom is not necessary.

18.2 Severe sepsis and septic shock
Severe sepsis is defined as sepsis accompanied by associated organ dysfunction in one or more organs. Severe sepsis may result from serious insult to the body such as burns or other trauma that precipitates infection. Septic shock may occur with severe sepsis

A minimum of three codes are required to fully code a case of severe sepsis. The first code should be the infection code, usually a code from Chapter 1. The second code required is a code from subcategory R65.2, Severe sepsis. The codes under R65.2 indicate if septic shock is present. The third code(s) assigned identifies any associated organ dysfunction. A use additional code note with a list of commonly associated organ dysfunction codes is provided under R65.2.

See guideline 1.2 Sepsis.

18.3 Encounter for pain management

The reason for visit for a patient with a serious, chronic health problem or who has undergone complex treatments may be pain management. In such a case, the pain code should be the first listed or principal diagnosis. Category R52, Pain, not elsewhere classified, has subcategories for acute pain (R52.0-), chronic intractable pain (R52.1-), and other chronic pain (R52.2-). Within each subcategory are specified codes for postoperative pain and pain in neoplastic disease, as well as unspecified pain. Generally, patients admitted for pain management suffer from chronic intractable pain. Patients who have serious postoperative pain may also be admitted for pain management.

The underlying condition causing the pain should also be coded, but it should not be the first listed if the reason for the encounter and the treatment given is for pain management. Codes from R52 may also be used as secondary codes if pain management is a component of treatment for another health problem.

Category R52 is not for use in place of site-specific pain codes. The site-specific pain codes are for use to describe the symptom that leads a physician to perform a diagnostic work-up.

18.4 Falling

Code R26.81, Falling, should not be confused with the external cause codes for falls. The external cause fall codes describe the event that causes an injury. Code R26.81 is the code to be assigned when a patient tends to fall when attempting to walk.

R26.81 may be used in conjunction with an external cause code for falls, if the patient sustains an injury due to a fall. The external cause code describes the type of fall. The injury code should be the first listed code. The underlying condition that is responsible for the patient's tendency to fall should be coded first, if known.

18.5 Glasgow coma scale

ICD-10-CM contains the Glasgow coma scale (R40.2-) to be used in conjunction with traumatic brain injury codes or sequelae of cerebrovascular accident codes. Three codes, one from each subcategory, are needed to complete the scale.

If multiple coma assessments are done, a patient should receive an initial scale rating at time of admission and a final rating at discharge. Each facility needs to establish an in-house policy to determine which scale rating(s) to record on the medical record. An extension must be added to the coma codes to indicate which rating(s) is being maintained for the final record.

18.6 Death NOS

Code R99, Ill-defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into the emergency department or other healthcare facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

Chapter 19: Injury, poisoning and certain other consequences of external causes
Chapter 19 is divided into two sections, the "S" codes and the "T" codes. The "S" codes are the traumatic injury codes. The "T" codes are the burns and corrosions, poisonings and toxic effects, adverse effects and underdosing, complications of medical care and other such consequences of external causes.

19.1 Chapter 19 code extensions
Most categories in Chapter 19 have 7th character extensions that are required for each applicable code. There are three extensions used for most categories: a, initial encounter, d, subsequent encounter, and q, sequela. Fracture categories have different extensions. See guideline 19.2.2.1 Fracture extensions.

19.1.1 Extensions "a" and "d"
Extension a, initial encounter, is for use only for the initial (first) encounter for treatment of an injury. All subsequent encounters require extension d, subsequent encounter. An injury code with extension "d" may be used for as long as a patient is receiving treatment for an injury. The use of the extensions will enable the tracking of injury treatment for the entire course of treatment while still identifying the type of injury. See guideline 21.2.9, Aftercare.

If an injury is not new at the time of the first encounter, due to the patient's delay in seeking treatment, it is still considered the initial encounter. However, even if a physician is seeing a patient for treatment of an injury for the first time, if treatment for the injury has been provided by any other medical professional previously, it should be coded as a subsequent treatment encounter. The default extension, in cases when it is not known, is extension a, initial treatment.

19.1.2 Extension "q"
Extension q, sequela, is for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn. When using extension "q," it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "q" is added only to the injury code, not the code that specifies the sequela. The "q" identifies the injury responsible for the sequela. The sequela is sequenced first, followed by the injury code.

19.2 "S" codes
The injury codes are very specific, but provide a great deal of detail. Each injury code describes a single component of an injury. Assign a separate code for each component of an injury. As many codes as are needed to fully describe the injury should be used. At each category, there are instructional notes that indicate which other codes may be required to fully describe an injury. For example, at all open wound categories there is an instructional note to code any associated wound infection.

When sequencing injury codes, the most severe injury should be sequenced first.

A wound code from this chapter should not be used for normal, healing surgical wounds.

The "S" codes are divided into body sections, head (S00-S09), neck (S10-S19), thorax (S20-S29), abdomen, lower back, lumbar spine and pelvis (S30-S39), shoulder and upper arm (S40-S49), elbow and forearm (S50-S59), wrist and hand (S60-S69), hip and thigh (S70-S79), knee and lower leg (S80-S89), and ankle and foot (S90-S99).

Within each body section are categories for types of injuries: superficial wounds, open wounds, fractures, dislocations, injuries to nerves, injuries to blood vessels, crush injuries and injuries to the internal organs that are specific to the body section.

19.2.1 Superficial and open wounds

Superficial wounds are divided into: contusions, abrasions, blisters, external constriction (such as, a rubber band constricting a finger), superficial foreign body, insect bite and other superficial bite.

Open wounds are divided into: lacerations without foreign body, laceration with foreign body, puncture wound without foreign body, puncture wound with foreign body, and open bite.

There may be overlap or imprecision in describing these types of wounds in medical record documentation. It is necessary to assign codes based on the terms used in the record. If a wound is described as a laceration, it is coded to laceration. If it is described as an abrasion, it is coded to abrasion. Bite NOS defaults to open bite.

Superficial wounds are not coded when associated with more severe injuries of the same site.

19.2.2 Fractures

Fractures are coded individually by site. As many fracture codes as are needed to fully describe the fractures should be used. The most serious fracture is sequenced first. A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced.

19.2.2.1 Fracture extensions

In addition to the extensions for initial encounter, subsequent encounter and sequela that the other "S" codes have, the fracture codes have additional extensions indicating open or closed fracture, routine healing, delayed healing, nonunion and malunion of fractures.

Open fractures of long bones have extensions for degree of severity. The default extension for open fractures is b, initial encounter for treatment of open fracture type I or II.

The fracture extensions are unique to each type of bone and type of fracture. It is necessary to review the fracture extensions carefully before assigning an extension.

A fracture code with the appropriate extension should be assigned for as long as a patient is receiving treatment for a fracture. The extension may change with each encounter.

19.2.3 Crush injuries

The crush injury code should be sequenced first, followed by all applicable codes that indicate the specific injuries associated with the crushing.

19.2.4 Amputations

Amputation codes include the fracture of the bone of the amputated site. No additional fracture code is necessary with an amputation code. If not documented whether complete or partial, an amputation should be coded to complete.

19.2.5 Spinal cord injuries

For each section of spinal cord injury, the code for the highest level of injury for that section of the cord should be used. So, for example, for injuries of the cervical spinal cord, code to the highest level of injury of the cervical cord if the cervical cord is injured in more than one location. If a patient has a cord injury at more than one section of the cord, cervical and thoracic, for instance, use a code for the highest level of injury for each section. If the patient has a complete lesion of the cord, it is not necessary to use any additional codes for spinal cord injuries below the level of the complete lesion.

19.2.6 Use of an external cause code (Chapter 20) with an injury code

When an injury code is assigned to a medical record, a corresponding external cause code must also be assigned to identify the cause of the injury. Additionally, an activity code (Y93) and a place of occurrence code (Y92) should also be assigned. Place of occurrence codes are not required for adverse effects, poisonings and toxic effects.

Should an injury be work related (activity done for income), assign an activity code with extension 2.

See guidelines for Chapter 20 for instructions on the use of external cause codes.

19.3 “T” codes

19.3.1 Burns and corrosions

The ICD-10-CM distinguishes between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. If a burn is a thermal burn, a burn code should be used. If a burn is a chemical burn, a corrosion code should be used. The guidelines for burns and corrosions are the same.

Current burns and corrosions of the external body surface (T20-T25) are classified by site and by depth: first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.

Assign separate codes for each burn or corrosion site. Sequence first the code that reflects the highest degree of burn or corrosion when more than one site is affected. Sequence internal burns and corrosions before burns of the external body surface if they are more severe or require more extensive treatment. Classify burns or corrosions of the same local site, but of different degrees, to the highest degree recorded in the diagnosis.

19.3.1.1 Non-healing or infected burns and corrosions

Non-healing burns or corrosions are coded as acute burns or corrosions. Necrosis of burned skin should be coded as a non-healed burn.

For any documented infected burn site, use an additional code for the infection.

19.3.1.2 Burn NOS, Corrosion NOS

Code T30.0, Burn of unspecified body region, unspecified degree, and code T30.4, Corrosion of unspecified body region, unspecified degree, should only be used if the location of the burns or corrosions are not documented. These codes are never for use in the inpatient setting.

19.3.1.3 Burns and corrosions classified according to extent of body surface involved

Assign an additional code from category T31, Burns classified according to extent of body surface involved, or T32, Corrosions classified according to extent of body surface involved, to indicate the total body surface burned. It is advisable to use these codes to provide data for evaluating burn morbidity and mortality, such as that needed by burn units. It is also recommended to use a code from category T31 for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.

Categories T31 and T32 are based on the classic “rule of nines” in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Physicians may change these percentage assignments where necessary to accommodate infants and children

who have proportionately larger heads than adults and patients who have large buttocks, thighs, or abdomen that involve burns or corrosions.

19.3.1.4 Use of an external cause code with burns and corrosions
External cause code(s) should be used with burns and corrosions to indicate the source of the burn, the place where it occurred and the activity of the patient at the time of the incident.

19.3.1.5 Sequela of burns and corrosions
Extension "q" should be assigned to a burn or corrosion code to indicate that a sequela of the burn or corrosion exists. See guideline 19.1.2 Extension q.

When appropriate, both a code for a current burn or corrosion with extension "a" or "d", and a burn or corrosion code with extension "q" may be assigned on the same record. Burns and corrosions do not heal at the same rate and a current healing wound may still exist with a sequela of a healed burn or corrosion.

19.3.2 Poisonings, toxic effects, adverse effects and underdosing
A poisoning is an overdose of a drug or a drug given or taken in error. When an error is made in a drug prescription or in the administration of a drug by a physician, nurse, patient, or other person, it is considered a poisoning. If a nonprescribed drug or medicinal agent is taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs is classified as a poisoning.

A toxic effect is a poisoning due to a toxic substance that has no medicinal use.

An adverse effect is a reaction to a drug that is taken as prescribed and is properly administered.

Underdosing is taking less of a medication than is prescribed by a physician or the manufacturer's instruction with a resulting negative health consequence. A noncompliance (Z91.12-, Z91.13-) or failure in dosage during surgical or medical care (Y63.-) code must be used with an underdosing code to indicate intent.

Categories T36-T50, Poisoning, adverse effects and underdosing by drugs, medicaments and biological substances, and T51-T65, Toxic effects of substances chiefly nonmedicinal as to source, are the categories for the different classes of drugs and chemical agents that may cause a poisoning, toxic effect or adverse effect.

Poisonings and toxic effects have an associated intent: accidental, intentional self-harm, assault, and undetermined. The final characters 1,2, 3, and 4 for each code in these categories, usually the 6th character, indicates the intent. The final character 5 for categories T36-T50 indicates an adverse effect. The final character 6 for categories T36-T50 indicate underdosing.
The final characters are as follows:
1 accidental (unintentional)
2 intentional self-harm
3 assault
4 undetermined
5 adverse effect (for categories T36-T50 only)
6 underdosing (for categories T36-T50 only)

When no intent is indicated, the default is accidental. Undetermined intent is only for use when there is specific documentation in the medical record that the intent of the poisoning or toxic effect cannot be determined.

No additional external cause code is required for poisonings, toxic effects, adverse effects and underdosing codes.

19.3.2.1 5th character "x" place holder
The 5th character "x" at many of the codes in categories T36-T65 is a dummy place holder to allow for possible future expansion. The "x" must remain in the code and no other character should be used in its place.

19.3.2.2 Sequencing of poisonings, toxic effects, adverse effects and underdosing
A code from categories T36-T65 is sequenced first, followed by the code(s) that specifies the nature of the poisoning, toxic effect or adverse effect.

19.3.2.3 Poisonings, toxic effects, adverse effects and underdosing in a pregnant patient
Codes from Chapter 15, Pregnancy, childbirth, and the puerperium, are always sequenced first on a medical record. A code from subcategory O94.2, Injury, poisoning and certain other consequences of external causes complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate poisoning, toxic effect, adverse effect or underdosing code and the additional code(s) that specify the nature of the poisoning, toxic effect, adverse effect or underdosing.

19.3.3 Other "T" codes that include the external cause
In addition to the poisonings, toxic effects, adverse effects and underdosing, certain other "T" codes are combination codes that include the external cause. For example, the codes in categories T17-T19, Effects of foreign body entering through natural orifice, identifies both the foreign body, as well as the resulting injury. The intent for these codes is accidental. No secondary external cause code is needed.

For category T71, Asphyxiation, in addition to the external cause and the resulting injury, the intent is included at the final character. The intent codes are the same as those for the poisonings, toxic effects and adverse effects codes.
The final characters are as follows:
1 accidental (unintentional)
2 intentional self-harm
3 assault
4 undetermined

When no intent is indicated, the default is accidental. Undetermined intent is only for use when there is specific documentation in the medical record that the intent of the poisoning or toxic effect cannot be determined.

19.3.4 Adult and child abuse, neglect and other maltreatment
The ICD-10-CM has two categories for abuse and neglect, T74, Adult and child abuse, neglect and other maltreatment, confirmed, and T76, Adult and child abuse, neglect and other maltreatment, suspected. A code from these categories is sequenced first, followed by any accompanying mental health or injury code(s).

If the documentation in the medical record states abuse or neglect it is coded to confirmed. It is coded as suspected if it is documented as suspected.

If a suspected case of abuse, neglect or mistreatment is ruled out during an encounter, code Z04.71, Suspected adult physical and sexual abuse, ruled out, or code Z04.72, Suspected child physical and sexual abuse, ruled out, should be used, not a code from T76.

19.3.4.1 Use of an external cause code with an abuse or neglect code
For cases of confirmed physical abuse, an external cause code from the assault section (X92-Y08) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known.

19.3.4.2 Abuse and other maltreatment in a pregnant patient
Codes from Chapter 15, Pregnancy, childbirth, and the puerperium, are always sequenced first on a medical record. A code(s) from subcategories O94.3, Physical abuse complicating pregnancy, childbirth, and the puerperium, O94.4, Sexual abuse complicating pregnancy, childbirth, and the puerperium, and O94.5, Psychological abuse complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by any accompanying mental health or injury code(s). No code from category T74 or T76 is needed.

19.3.5 Complications of surgical and medical care, not elsewhere classified

19.3.5.1 Complication codes that include the external cause
As with certain other T codes, some of the "complications of care" codes have the external cause included in the code. An example is subcategory T81.5, Complications of foreign body accidentally left in body following procedure. The code includes the nature of the complication as well as the type of procedure that caused the complication. No external cause code indicating the type of procedure is necessary with a code from T81.5.

19.3.5.2 Mechanical complications
A mechanical complication of a medical device, implant or graft is defined as one of the following:

Mechanical breakdown
Displacement or malposition
Leakage
Obstruction
Perforation
Protrusion

If a repair of a medical device, implant or graft is done to correct one of the complications defined above, a mehancial complication code should be assigned.

19.3.5.3 Organ Transplant complications
Organ transplant rejection, failure or infection are complications. Category T86, Complications of transplanted organs and tissue, has codes for these specified types of complications. Should a physician document that another problem a patient may be experiencing is associated with a transplanted organ, it should also be coded as a complication. See guideline 21.2.6 Status, for transplant status coding.

19.3.5.4 Complications of care codes within the body system chapters
Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.

The categories are as follows:

D78 Intraoperative and postprocedural complications of procedures on the spleen
E36 Intraoperative and postprocedural complications of endocrine procedures
G97 Intraoperative and postprocedural complications and disorders of nervous system, not elsewhere classified
H59 Intraoperative and postprocedural complications and disorders of eye and adnexa, not elsewhere classified
H95 Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified

I97 Intraoperative and postprocedural complications and disorders of the circulatory system, not elsewhere classified
J95 Intraoperative and postprocedural complications and disorders of the respiratory system, not elsewhere classified
K91 Intraoperative and postprocedural complications and disorders of the digestive system, not elsewhere classified
L76 Intraoperative and postprocedural complications of dermatologic procedures
M96 Intraoperative and postprocedural complications and disorders of the musculoskeletal system, not elsewhere classified
N99 Intraoperative complications and postprocedural disorders of genitourinary system, not elsewhere classified

Chapter 20: External causes of morbidity

20.1 General Chapter 20 guidelines

External cause codes for injuries and other health conditions provide data for research and prevention strategies. These codes capture the cause of the injury or health condition, the intent (unintentional (accidental), intentional self-harm, or, assault), the place where the event occurred, and the activity of the patient at the time of the event. **External cause codes are never to be recorded as a principal/first listed diagnosis**.

An external cause code may be used with any code in the classification that is a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack, that occurs during strenuous physical activity. They are for use in any health care setting.

Assign as many external cause codes as necessary to fully explain each cause. The sequencing of multiple external cause codes is based on the sequence of events leading to the injury. If only one external cause code can be recorded, assign the external cause code that relates to the principal/first-listed diagnosis. The place of occurrence and activity code are sequenced after the main external cause code. Regardless of the number of external cause codes assigned there should be only one place of occurrence code and one activity code assigned to a record.

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall that results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

External cause codes for child and adult abuse take sequencing priority over all other external cause codes. See guideline 19.3.4, Adult and child abuse, neglect and other maltreatment.

External cause codes for terrorism take sequencing priority over all other external cause codes except child and adult abuse.

External codes for cataclysmic events take sequencing priority over all other external cause codes except child and adult abuse and terrorism.

External cause codes for transport accidents take sequencing priority over all other external cause codes except cataclysmic events, child and adult abuse and terrorism.

The selection of the appropriate external cause code is guided by the Index to External Causes, a separate index in the ICD-10-CM, and by the instructional notes in Chapter 20. The main term for the external cause is located in the index. The code indicated in the index for the main term is verified in the Tabular List of Chapter 20. The conventions and rules for the classification also apply to Chapter 20. See guidelines Section I, ICD-10-CM Conventions, and Section II, General

Coding Guidelines.

The external cause codes are divided into sections. The first section, V00-X58, are the unintentional (accidental) injuries. The second section, X71-X83, are the intentional self-harm categories. The third section, X92-Y08, are the categories for assault. Categories Y21-Y33 are for undetermined intent. There are substantially more unintentional categories due to the nature of external cause codes. For prevention purposes, it is important to capture data on the cause of unintentional injuries. For self-harm and assault, it is the intent itself that is most important to capture.

There are also sections for legal interventions, operations of war, military operations, terrorism, complications of medical and surgical care and supplemental factors related to causes of morbidity classified elsewhere. Categories for place of occurrence and activity are located in the final section.

The external cause categories include:
Unintentional (accidental) injuries
- Transport accidents
- Falls
- Struck by or caught between objects
- Contact with objects
- Firearms
- Explosions
- Exposure to animate and inanimate mechanical forces and other external causes
- Non-transport drowning and submersion
- Smoke, fire and flames
- Cataclysms and other forces of nature

Intentional self-harm
Assaults
Undetermined intent
Legal interventions
Operations of war/ Military operations
Terrorism
Complications of medical and surgical care
Place of occurrence
Activity code
Other supplemental factors related to causes of morbidity classified elsewhere

Poisonings, toxic effects, adverse effects and underdosing and their associated intent are located in Chapter 19, categories T36-T65. See guideline 19.3.2 Poisonings, toxic effects, adverse effects, and underdosing.

No external cause code from Chapter 20 is needed if the external cause and intent is included in a

code from another chapter.

20.2 External cause code extensions
Codes from categories V00-Y35 require an extension to indicate whether the encounter is the initial encounter for treatment, a subsequent encounter for treatment, or the sequelae of an event. The extensions for these categories are as follows:
a initial encounter
d subsequent encounter
q sequelae

These extensions match the extensions for the non-fracture T codes that have extensions.

An external cause code may be used for every health care encounter for the duration of treatment of an illness or injury. Extension "a" should be used for the initial encounter, "d" for every subsequent encounter, and "q" for any encounter for treatment of the sequelae of an external cause. The initial encounter is the first time a patient is seen by any health care provider in any setting for treatment of an injury. It is still considered the initial encounter even if the injury was sustained earlier and the patient delayed seeking treatment. Any encounter after the initial encounter is recorded as subsequent treatment.

Different extensions are needed for Y93, Activity code. See guideline 20.10 Activity code.

No extensions are required for categories Y62-Y84, Complications of medical and surgical care, Y90, Evidence of alcohol involvement determined by blood alcohol level, Y92, Place of occurrence, (See guideline 20.9 Place of occurrence), or Y95, Nosocomial condition.

20.3 Unintentional (accidental) injuries:
The default for external cause is unintentional. If there is no documentation in the medical record as to the intent of an injury, it should be assigned an "unintentional intent" external cause code.

The external cause categories V00-X58 are "unintentional intent" categories.

20.3.1 Transport accidents
See the Tabular list at V00-V99 for definitions related to transport accidents. It is important to review all instructional notes at the transport accident categories to properly select the correct code.

This section is structured in 12 groups reflecting the victim's mode of transportation. The type of vehicle the victim is an occupant in is identified in the first two characters since it is seen as the most important factor to identify for prevention purposes.

A transport accident is one in which the vehicle involved must be moving or running or in use for transport purposes at the time of the accident.

When accidents involving more than one kind of transport are recorded, the following order of precedence should be used:
aircraft and spacecraft (V95-V97)
watercraft (V90-V94)
other modes of transport (V00-V89, V98-V99)

Where transport accident descriptions do not specify the victim as being a vehicle occupant and the victim is described by terms such as, crushed, dragged, hit, run over etc., classify the victim as a pedestrian.

If no documentation is available as to whether the victim was the driver or occupant of a vehicle, classify the victim as an occupant.

Use additional external cause codes with a transport accident code to identify:
the use of a cell phone or other electronic equipment contributing to the accident (Y93.5-)
whether an airbag contributed to any injury (W22.1)
the type of street or road where the accident occurred, if known, (Y92.4-)

20.3.2 Falls
Categories W00-W19, Falls, include the main fall codes in Chapter 20. These codes are for standard types of falls, such as, due to ice and snow, falling from stairs or off a ladder. There are other fall codes in Chapter 20 for falls associated with other causes, such as, fires, watercraft accidents, pedestrian conveyance accidents or with subsequent striking against objects. A complete review of the index is necessary when selecting a fall code to be sure that the correct category and code are assigned.

20.4 Assault
If a patient's injury has been intentionally inflicted by another person, by any means, with intent to kill or injure, it is classified as an assault. A code from the assault categories (X92-Y08), should be used to record the external cause of the injury.

Assault does not include injuries as a result of legal intervention, operations of war, military operations or terrorism. See guidelines 20.5 Undetermined intent, and 20.6 Legal interventions, 20.7, Operations of war/military operations, and 20.8 Terrorism.

20.4.1 Adult and child abuse, neglect and maltreatment
The external cause for adult and child abuse is classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from abuse. For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from Y07, Perpetrator of maltreatment and neglect, should accompany any other assault codes. See

guideline 19.3.4 Adult and child abuse, neglect and maltreatment.

20.5 Undetermined intent
The default for injuries when the documentation does not indicate intent is unintentional. Codes from categories Y20-Y33, Events of undetermined intent, are only for use when the documentation in the record specifically states that the intent cannot be determined.

20.6 Legal interventions
The codes from category Y35, Legal intervention, are for use for any injury documented as sustained as a result of an encounter with any law enforcement official, serving in any capacity at the time of the encounter, whether on-duty or off-duty. The sixth-character for the legal intervention codes identifies the victim, a law enforcement official, a bystander or the suspect of a crime

The extensions for Y35 are the same as for the majority of categories in Chapter 20:
a initial encounter
d subsequent encounter
q sequelae

See guideline 20.2 External cause code extensions.

20.7 Operations of war/ Military operations
Category Y36, Operations of war, is limited to classifying injuries sustained during a time of declared war and that are directly due to the war. Y37, Military operations, is for use to classify injuries to military and civilian personnel occurring during peacetime on military property or during routine military exercises or operations.

The extensions for Y36 and Y37 are the same as for the majority of categories in Chapter 20:
a initial encounter
d subsequent encounter
q sequelae

Transport accidents during peacetime involving military vehicles that are off military property are included with the transport accidents, not in Y36 or Y37.

20.8 Terrorism
When the cause of an injury is identified by the Federal Bureau of Investigations (FBI) as terrorism, the first-listed external cause code should be a code from category Y38, Terrorism. The definition of terrorism is found at the beginning of the category. The code selected from Y38 should be the only external cause code assigned to a medical record. More than one Y38 code may be assigned if the injury is the result of more than one mechanism of terrorism.

Only injuries confirmed to be due to terrorism should be assigned a code from Y38. Suspected cases should be classified as assault.

Y38.9, Terrorism, secondary effects, is for use to identify injuries occurring subsequent to a terrorist attack, not due to the initial attack itself.

The extensions for Y38 are the same as for the majority of categories in Chapter 20:
a initial encounter
d subsequent encounter
q sequelae

20.9 Place of Occurrence
Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use with other external cause codes to identify the location of the patient at the time of injury. A place of occurrence code is used only once, at the initial encounter for treatment. Only one code from Y92 should be recorded on a medical record. A place of occurrence code should be used in conjunction with an activity code, Y93.

Use place of occurrence code Y92.9 if the place is not stated or is not applicable. Place of occurrence codes are not necessary with poisonings, toxic effects, adverse effects or underdosing codes.

No extensions are used for Y92.

20.10 Activity code
Codes from category Y93, Activity code, are secondary codes for use with other external cause codes to identify the activity of the patient at the time of the injury. An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record. An activity code should be used in conjunction with a place of occurrence code, Y92.

Use activity code Y93.9 if the activity of the patient is not stated or is not applicable.

Specific 7th character extensions are required for Y93:
1 non-work related activity
2 work-related activity
3 student activity
4 military activity

If a patient is a student but is injured while performing an activity for income, use extension 2.

Chapter 21: Factors influencing health status and contact with health service

21.1 General Chapter 21 Guidelines

Chapter 21, Factors influencing health status and contact with health services, (the Z codes) are provided to deal with occasions when circumstances other than a disease or injury classifiable to the other chapters of the ICD-10-CM are recorded as a reason for encounters with a health care provider. There are 4 primary circumstances for the use of Z codes:

1. When a person who is not currently sick has a health care encounter for some specific reason, such as, to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on a health related issue.

2. When a person with a resolving disease or injury or a chronic, long-term condition requiring continuous care has a health care encounter for specific aftercare of that disease or injury, such as, dialysis for renal disease or chemotherapy for a malignancy. A diagnosis/symptom code, not a Z code, should be used whenever a current, acute condition is being treated or a sign or symptom is being studied.

3. When circumstances or problems influence a person's health status but are not in themselves a current illness or injury.

4. For newborns, to indicate birth status

Z codes are for use in both the inpatient and outpatient setting but are generally more applicable in the outpatient setting.

Z codes may be used as either principal/first-listed codes or as secondary codes, depending on the circumstances of the encounter. Certain Z codes may only be first-listed, others only secondary. The Z code Table at the end of the Z code guidelines identifies the sequencing restrictions for the Z code categories.

A Z code may be assigned based on any documentation in the medical record, including nursing and therapist notes, unless the Z code is the principal/first listed, in which case there must be physician documentation.

Z codes indicate a reason for an encounter. They are not procedure codes. A corresponding procedure code must accompany a Z code to describe a procedure performed.

21.2 The Z code categories

21.2.1 General and administrative examinations

The categories for general and administrative examinations describe encounters for routine examinations. These are "reason for visit" categories. Any procedures performed must be identified with separate procedure codes from the appropriate procedure classification. The codes from these categories are first listed codes. They are not for use if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases, a confirmed diagnosis, sign or symptom code should be used.

Category Z00, Encounter for general examination without complaint, suspected or reported diagnosis, and category Z01, Encounter for other special examination without complaint or suspected or reported diagnosis, include subcategories for general medical examinations, including eye, ear, and dental examinations, general laboratory and radiology examinations, routine child health examinations, as well as encounters for examinations for potential organ donors and controls for participants in clinical trials. Category Z02, Encounter for administrative examinations, includes codes for such things as pre-employment physicals.

The final character of the general health examination codes distinguishes between "without abnormal findings" and "with abnormal findings." For these encounters, if an abnormal condition is discovered, the code for "with abnormal findings" should be used. A secondary code for the specific abnormal finding should be used.

Subcategories Z00.02, Encounter for general laboratory examination, and Z00.03, Encounter for general radiology examination, are only for use if the only reason for the encounter is for routine blood work or x-rays that are a component of a general examination but are occurring independently of the full medical examination. They are not to be used if an encounter is for diagnostic lab work or x-rays. For such cases, codes for the sign or symptom or condition being investigated should be used.

Pre-operative examination codes, Z01.81-Z01.84, are for use only in those situations when a patient is being cleared for surgery and no other treatment is given.

Pre-existing and chronic conditions, as long as the examination does not focus on them, may also be assigned with codes from Z00-Z02.

21.2.2 Observation

An observation encounter is one when a person without a diagnosis is suspected of having an abnormal condition following an accident or incident, that might result in a health problem, but without signs or symptoms, that after examination and observation is ruled out. They are for use in very limited circumstances when a person is being observed for a suspected condition that is found not to exist. The fact that the patient may be scheduled for a return encounter following the initial observation encounter does not limit the use of an observation code.

There are two observation categories, Z03, Encounter for medical observation for suspected diseases and conditions, ruled out, and Z04, Encounter for observation for other reasons.

An observation code should not be used for a patient with any illness, injury or signs and symptoms. The illness, injury, signs or symptoms should be coded, with the corresponding external cause code. Pre-existing and chronic conditions may also be assigned with codes from Z03-Z04, as long as they are not associated with the suspected condition being observed.

21.2.3 Follow-up

The follow-up codes are for use to describe encounters for continuing surveillance following completed treatment of a disease, condition or injury. Follow-up infers that the condition has been fully treated and no longer exists. It should not be confused with aftercare that explain current treatment for a healing or long-term condition. See guideline 21.2.9 Aftercare.

Follow-up codes should be used in conjunction with history (of) codes to provide the full picture of the healed or treated condition. The follow-up code is sequenced first, followed by the history (of) code.

A follow-up code may be used for repeated visits, such as the long-term follow-up of cancer. If a condition is found to have recurred on a follow-up visit, the follow-up code should still be used, followed by the diagnosis code.

The two follow-up codes are Z08, Encounter for follow-up examination after completed treatment for malignant neoplasm, and Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm. When using Z08, it is necessary to assign the appropriate secondary code from category Z85, Personal history of primary and secondary malignant neoplasm.

21.2.4 Screening

Screening is the testing for disease or disease precursors in seemingly healthy individuals so that early detection and treatment can be provided for those who test positive for the disease. Screenings are recommended for many subgroups in a population, such as, a routine mammograms for women over 40, a fecal occult blood test or colonoscopy for anyone over 50, or an amniocentesis to rule out a fetal anomaly for pregnant women over 35, because the incidence of breast cancer and colon cancer in these subgroups is higher than in the general population, as is the incidence of Down syndrome in older mothers.

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic test, not a screening. For these cases, the code for the sign or symptom is used to explain the test, not the screening code.

A screening code may be a first listed code if the reason for the encounter is specifically the screening. They may also be used as an additional code(s) if the screening is done during an

encounter for other health reasons. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during a screening, the screening code should still be used, followed by the code for the condition that is discovered.

The screening codes are "reason for visit" codes. A procedure code from the appropriate procedure classification is required to indicate which tests were performed.

The screening categories are:
Z11 Encounter for special screening examination for infectious and parasitic diseases
Z12 Encounter for special screening examination for malignant neoplasm
Z13 Encounter for special screening examination for other diseases and disorders

21.2.5 Contact/Exposure
Codes from Category Z20, Contact with and exposure to communicable diseases, are for patients who do not show any signs or symptoms of a disease but who have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic. These codes may be used as a first listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

21.2.6 Status
Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the use of a prosthetic or mechanical device. A status code is informative because the status may affect any current treatment and its outcome. A status code is distinct from a history code. A history code indicates that the patient no longer has a condition. See guideline 21.2.12 History (of).

The status Z categories/subcategories/codes are:
Z14 Genetic carrier
This category indicates that a person is a carrier of a non-infectious condition that may be passed on genetically to any offspring. The carrier does not have the condition itself. Codes from Z14 are most often for use for pregnancy women who may pass on an hereditary condition to a fetus.
Z15 Genetic susceptibility to disease
Codes from this category indicate that a person has a gene that increases the risk of getting certain conditions, most notably cancer. A code from Z15 will most often be for use to explain the reason for a prophylactic procedure.
Z16 Infection with drug-resistant microorganism
This code indicates that a patient has an infection that is resistant to antibiotics. Sequence the infection code first.
Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
This code indicates that a patient has tested positive for HIV but has no signs or

symptoms of the disease. See guideline 1.1 Human immunodeficiency virus [HIV] disease.

Z22 Carrier of infectious disease
Carrier status indicates that a person harbors a specific organism of a disease without symptoms but is capable of transmitting the infection to others. This category is also for use for suspected carriers.

Z33.1 Pregnant state, incidental
This is a secondary code only for use when a pregnancy is in no way complicating the reason for a health care encounter. See guideline 15.1 General Chapter 15 Guidelines.

Z79 Long-term (current) drug therapy
This category indicates a patient's continuous use of a drug (prescribed or over the counter) for the long-term treatment of a condition or for prophylactic use. It does not indicate an addiction to a drug.

Z88 Allergy status to drugs, medicaments and biological substances
Drug allergies are life-long. Codes from this category should be added to a patient's record at every encounter to caution that a patient suffers from a drug allergy.

Z89 Acquired absence of limb

Z90 Acquired absence of organs, not elsewhere classified

Z91.0 Allergy status, other than to drugs and biological substances
This subcategory includes allergies to foods, insects, and other nonmedicinal substances, such as latex. Allergies are life-long. Codes from this subcategory should be added to a patient's record at every encounter to caution that a patient suffers from an allergy.

Z91.7 Low birth weight and immaturity status

Z93 Artificial opening status

Z94 Transplanted organ and tissue status

Z95 Presence of cardiac and vascular implants and grafts

Z96 Presence of other functional implants

Z97 Presence of other devices

Z98 Other postsurgical states

Z99 Dependence on enabling machines and devices, not elsewhere classified

Categories Z89-Z99 are for use only if there is no complication or malfunction of the organ or tissue replaced, of the amputation site, or the equipment on which the patient is dependent. These are always secondary codes.

21.2.7 Encounter for immunization/Immunization not carried out

Code Z23, Encounter for immunization, is for use to indicate that a patient is being seen to receive a prophylactic inoculation against a disease. **The injection itself must be indicated with a procedure code**. This code may be used as a secondary code if the inoculation is given as a part of preventive health care, such as a well-baby visit.

Immunizations against many communicable diseases is required in most states for admission to school or for employment. For persons who choose not to receive an immunization for personal

or health reasons, a code from category Z28, Immunization not carried out, should be used to identify the reason a required immunization is not given.

21.2.8 Encounters for health services related to reproduction

The categories/code related to reproduction include:

Z30 Encounter for contraceptive management
Z31 Encounter for procreative management
Z32 Encounter for pregnancy test and instruction
Z33.2 Encounter for elective termination of pregnancy
(Code Z33.1, Pregnancy state, incidental, is a status code)
Z34 Encounter for supervision of normal pregnancy
Z36 Encounter for antenatal screening
Z37 Outcome of delivery
Z38 Liveborn infant according to place of birth and type of delivery
Z39 Encounter for maternal postpartum care and examination

See guidelines for Chapter 15 for instructions on the use of codes from categories Z30-Z37, and code Z33.2.

See guidelines for Chapter 16 for instructions on the use of Z38.

These encounter codes identify the reason for visit. Any procedures performed must be identified with a procedure code from the appropriate procedure classification.

21.2.9 Aftercare

Aftercare visit codes, with such category titles as fitting and adjustment, and attention to artificial openings, cover situations when the initial treatment of a disease or injury has been performed and the patient requires continuing care during the healing or recovery phase, or for the long-term consequences of an illness. The aftercare Z codes should not be used if treatment is directed at a current disease or injury. The disease or injury code should be used in such cases. See guideline 19.1.1 Extensions "a" and "d".

The aftercare codes are generally first listed, "reason for visit" codes. An aftercare code may also be used as a secondary code, when some type of aftercare is provided in addition to another reason for an encounter and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Certain aftercare codes need a secondary diagnosis code to describe the resolving condition or sequelae. For others, the condition is inherent in the code title.

Aftercare codes are not for use for mechanical complications or malfunctioning of a device. See guideline 19.3.5.2 Mechanical complications.

The aftercare categories are:
Z43 Encounter for attention to artificial openings
Z44 Encounter for fitting and adjustment of external prosthetic device
Z45 Encounter for adjustment and management of implanted device
Z46 Encounter for fitting and adjustment of other devices
Z47 Orthopedic aftercare
Z48 Encounter for other surgical aftercare
Z49 Encounter for care involving renal dialysis
Z51 Encounter for other aftercare

21.2.9.1 Encounter for radiation therapy and chemotherapy
For patients whose encounter is specifically to receive radiation therapy and chemotherapy, codes Z51.0, Encounter for radiotherapy session and Z51.1, Encounter for chemotherapy session for neoplasm, are to be sequenced first, followed by the code for the condition being treated. If a patient receives both radiation and chemotherapy during the same encounter both codes should be used, with either sequenced first.

21.2.10 Donor
Category Z52, Donors of organs and tissues, include the donor codes. They are for use for living individuals who are donating blood or other body tissue. These codes are only for individuals donating for others, not for self donations. They are not for use to identify cadaveric donations.

21.2.11 Counseling
Counseling Z codes are for use when a patient or family member of a patient receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems. These Z codes may be used alone, without a diagnosis code, if the encounter is solely for counseling. They are not necessary for use in conjunction with a diagnosis code when the counseling component of care is integral to standard treatment.

The counseling categories are:
Z69 Encounter for mental health services for victim and perpetrator of abuse
Z70 Counseling related to sexual attitude, behavior and orientation
Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified

21.2.12 History (of)
There are two types of history (of) codes, personal history and family history. Personal history codes indicate a patient's past medical condition that no longer exists but that has the potential for recurrence, and, therefore, may require continued monitoring.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes should be used in conjunction with follow-up codes to explain the condition being followed. Family history codes should be used in conjunction with screening codes to explain the need for a test or procedure, if a family history of the condition being screened for is applicable.

Personal history codes are acceptable on any medical record regardless of the reason for the encounter. A personal history or an illness or condition, even if no longer present, is important information that may alter the type of treatment given.

The history (of) categories/codes are:
Z80 Family history of primary malignant neoplasm
Z81 Family history of mental and behavioral disorders
Z82 Family history of certain disabilities and chronic diseases (leading to disablement)
Z83 Family history of other specific disorders
Z84 Family history of other conditions
Z85 Personal history of primary and secondary malignant neoplasm
Z86 Personal history of certain other diseases
Z87 Personal history of other diseases and conditions
Z91.41 Personal history of adult physical and sexual abuse
Z91.49 Other personal history of psychological trauma, not elsewhere classified
Z91.5 Personal history of self-harm
Z92 Personal history of medical treatment

21.2.13 Miscellaneous Z codes
The miscellaneous Z codes capture a number of other health care encounters that do not fall into one of the other general areas. Certain of these codes identify the reason for an encounter that cannot be captured with a diagnosis code, others are for use as additional codes that provide useful information on circumstances that may affect a patient's care and treatment. These codes are generally secondary codes.

The miscellaneous categories/subcategory/codes are:
Z40 Encounter for prophylactic surgery
A family history code should be used following a code from Z40 to indicate the condition for which the patient is seeking prophylactic care.
Z41 Encounters for procedures for purposes other than remedying health state
Z53 Persons encountering health services for specific procedures and treatments, not carried out
Z55 Problems related to education and literacy
Z56 Problems related to employment and unemployment
Z57 Occupational exposure to risk-factors
Z58 Problems related to physical environment
Z59 Problems related to housing and economic circumstances
Z60 Problems related to social environment

Z61 Problems related to negative life events in childhood
Z62 Other problems related to upbringing
Z63 Other problems related to primary support group, including family circumstances
Z64 Problems related to certain psychosocial circumstances
Z65 Problems related to other psychosocial circumstances
Z66 Do not resuscitate
Z67 Blood type
Z72 Problems related to lifestyle
Z73 Problems related to life-management difficulty
Z74 Problems related to care-provider dependency
Z75 Problems related to medical facilities and other health care
Z76 Persons encountering health services in other circumstances
Z91.1 Noncompliance with medical treatment and regimen
Codes from this subcategory are for use when a patient does not take medication or follow therapy as prescribed. It is a distinct concept from poisonings and adverse effects.
Z91.3 Unhealthy sleep-wake schedule
Z91.8 Other specified personal risk-factors, not elsewhere classified

Z Code Table

FIRST LISTED

Z codes/categories/that are only acceptable as first listed.

Codes:

Z33.2 Encounter for elective termination of pregnancy
Z51.0 Encounter for radiotherapy session
Z51.1 Encounter for chemotherapy session for neoplasm
Z51.0 and Z51.1 may be used together on a record, with either one sequenced first, when a patient receives both during the same encounter.

Categories:

Z00 Encounter for general examination without complaint, suspected or reported diagnosis
Z01 Encounter for other special examination without complaint or suspected or reported diagnosis
Z02 Encounter for administrative examination
Z03 Encounter for medical observation for suspected diseases and conditions ruled out
Z04 Encounter for observation for other reasons
Z34 Encounter for supervision of normal pregnancy
Z38 Liveborn infants according to place of birth and type of delivery
Z39 Encounter for maternal postpartum care and examination
Z52 Donors of organs and tissues

FIRST OR ADDITIONAL

Z codes/categories that may be either first listed or additional.

Codes:

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
Z23 Encounter for immunization
Z51.81 Encounter for therapeutic drug level monitoring
Z51.89 Encounter for other specified aftercare

Categories:

Z08-Z09 Encounters for follow-up examinations
Z11-Z13 Encounters for special screening examinations
Z14 Genetic carrier
Z15 Genetic susceptibility to disease
Z20 Contact with and exposure to communicable diseases
Z22 Carrier of infectious disease
Z23 Encounter for immunization
Z79 Long-term (current) drug therapy
Z85-Z87 Personal history of disease
Z30 Encounter for contraceptive management

Z31 Encounter for procreative management
Z32 Encounter for pregnancy test and instruction
Z36 Encounter for antenatal screening
Z40 Encounter for prophylactic surgery
Z41 Encounter for procedures for purposes other than remedying health state
Z43 Encounter for attention to artificial openings
Z44 Encounter for fitting and adjustment of external prosthetic device
Z45 Encounter for adjustment and management of implanted device
Z46 Encounter for fitting and adjustment of other devices
Z47 Orthopedic aftercare
Z48 Encounter for other surgical aftercare
Z49 Encounter for care involving renal dialysis
Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z69 Encounter for mental health services for victim and perpetrator of abuse
Z70 Counseling related to sexual attitude, behavior and orientation
Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified
Z72 Problems related to lifestyle
Z73 Problems related to life-management difficulty
Z74 Problems related to care-provider dependency
Z75 Problems related to medical facilities and other health care
Z76 Persons encountering health services in other circumstances
Z89 Acquired absence of limb
Z90 Acquired absence of organs, not elsewhere classified

ADDITIONAL ONLY
Z codes/subcategories/categories that may be used only as additional codes.

Codes:
Z16 Infection with drug-resistant microorganisms
Z33.1 Pregnant state, incidental
Z51.5 Encounter for palliative care
Z66 Do not resuscitate
Z91.3 Unhealthy sleep-wake schedule
Z91.5 Personal history of self-harm

Subcategories:
Z91.0 Allergy status, other than to drugs and biological substances
Z91.1 Noncompliance with medical treatment and regimen
Z91.4 Personal history of psychological trauma, not elsewhere classified

Categories:

Z28 Immunization not carried out
Z37 Outcome of delivery
Z53 Persons encountering health services for specific procedures and treatment, not carried out
Z67 Blood type
Z80-Z84 Family history of disease
Z86 Allergy status to drugs, medicaments, and biologicals
Z92 Personal history of medical treatment
Z93 Artificial opening status
Z94 Transplanted organ and tissue status
Z95 Presence of cardiac and vascular implants and grafts
Z96 Presence of other functional implants
Z97 Presence of other devices
Z98 Other postsurgical states
Z99 Dependence on enabling machines and devices, not elsewhere classified